NTION OF A CRISIS
E NEW MILLENNIUM

ITED LECTURES

FINAL PROGRAM & INVI

SECOND INTERNATIONAL CONFERENCE

ON

AIDS INDIA 2000

CHENNAI (MADRAS), INDIA DECEMBER 6, 7 & 8, 1999

Organised by

The Department of Experimental Medicine

and AIDS Resource Center

Tamilnadu Dr. MGR Medical University, Chennai

Satellite Symposium

Management of HIV Infected Patients

Sponsored by

International AIDS Society

Dec 5, 1999

06137

Community Health Cell
Library and Documentation Unit
367, "Srinivasa Nilaya"
Jakkasandra 1st Main,
1st Block, Koramangala,
BANGALORE-560 034.
Phone : 5531518

Co- Sponsored by :

Tamilnadu State AIDS Control Society

National AIDS Control Society (NACO)

APAC

Office of AIDS Research, National Institutes of Health (NH), USA

International AIDS Society

Elizabeth Glaser Paediatric AIDS Foundation, USA

Global Strategies for HIV Prevention, USA

Glaxo Wellcome

Boehringer Ingelheim

Teddy Exports

Second International Conference
on

AIDS INDIA 2000

Chennai (Madras), India
December 6 - 8, 1999

FINAL PROGRAM
INVITED LECTURES

Organised by

The Department of Experimental Medicine
and
AIDS Resource Center
Tamilnadu Dr.M.G.R Medical University, Chennai

DIS325 N99
06137

COMMUNITY HEALTH CELL
LIBRARY
AND
DOCUMENTATION
UNIT
BANGALORE.

Welcome

It is our pleasure to invite you to the Second International Conference on AIDS India 2000 organised by the Department of Experimental Medicine and AIDS Resource Center of The TN Dr. MGR Medical University, Chennai India.

HIV was recognised much later in India than in the rest of the world. India now has 8.13 million HIV positive cases out of which 4,725 are reported to have developed AIDS. These figures though conservative, suggest that a quarter of the world's 30 million HIV infected people live in India and that the HIV epidemic is spreading much faster than first projected to with enormous economic implications.

The Combination regimens used in the developed countries have changed the face of HIV infection. These drugs are out of the reach of millions in developing countries. Even the commonly used drugs to prevent and treat opportunistic infections are scarce. Disposable needles/syringes and safe blood supply in the HIV/AIDS era remains an elusive but serious problem. Infected individuals whose return to active life is impossible are threatened with stigma, ostracism and lack of care and support by the community.

HIV disease is grossly underdiagnosed and the health care community is reluctant to manage the infected persons. There is need to re-evaluate and develop strategies to slow down the spread of HIV infection.

Despite preventive strategies and their success far from the goal, as they be, the epidemic in the young is unrelenting. One observes a sense of hopelessness and demotivation among the workers, who often work in very difficult circumstances.

This conference will have emphasis on the multifaceted issues and subjects which are becoming increasingly important in prevention of HIV infection

such as social, economic, ethical, political, religious and scientific etc. Others are preventive strategies for HIV infection in infants and HIV vaccines.

The conference will offer an opportunity for us to share our experiences and to learn from grass root workers, the scientists and the international community to develop new models of prevention.

The organising committee with the help of experts and organisations all over the world has designed this conference to be comprehensive and meaningful. Each individual attending this conference should go back with a sense of commitment to the urgent task of preventing this crisis in the new millennium.

Dr. K. Anandakannan
Vice-Chancellor
President

Dr. Mark. A Wainberg
President
International AIDS Society
Conference Chair

TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY
CHENNAI
HEALTH FOR ALL

Dear delegates from far and near!

To this historically and culturally renowned city of Chennai and to this great Confluence of Knowledge on AIDS, may I, as Chairman of the Scientific Session of the Conference, extend to every one, a special, hearty welcome, with folded hands.

Let us for a moment, look back into the history of health care. Leprosy took several decades to conquer. Tuberculosis consumed more than 30 years. But thanks to the dedication of the concerned people, the modern facilities for Re and development the classified knowledge base, the quick information recall and the communication systems now available, a dramatic improvement has taken place in the health care of HIV infected patients, within a very short span of a few years. To review this mind-boggling work and to plan for the total eradication of this near-terminal disease of AIDS in the new millennium, no wonder, Chennai in India has been chosen as the place to conduct this conference, India is the second most populous country in the world but ranks FIRST in terms of HIV population; hence it could benefit most, if the killer disease is checked and eradicated.

Besides the health care personnel, people from other walks of life too are eager to learn and update their knowledge about the disease.

We have tried our best to give you a panoramic view of this explosive growth in all aspects of HIV Medicine right from policy decisions through prevention, Virology, clinical presentations and procedures to the newest treatment strategies. The presentations are split into plenary, parallel and poster sessions. This is not all. There will be plenty of opportunities for participation, discussion, inter-action and exchange of ideas. Yes, all these with in just three days - the short duration of the conference, with all the learned speakers having assured us that they would stay within their time limits and allow adequate time for inter-active discussion and generation of potential ideas from the floor. We

are indeed very grateful to all these experts - both international and national, who have readily come forward to share their knowledge and experience.

Best possible back-up arrangements have been made for the parallel sessions in the various halls. Kindly do not hesitate to contact the volunteers of the scientific committee, if and when you need any help.

And now, ladies and gentlemen, the success of this Conference is very much in your hands the resource persons and delegates.

May I know conclude with a prayer to the good Lord Almighty to make this AIDS INDIA 2000, aid mankind effectively in their attempts to protect themselves from the killer disease, AIDS, Thank you one and all !

-Prof J.R. Sankaran
Chairperson scientific working committee

Welcome

Welcome to the 2nd Inter national Conference on AIDS India 2000. 652 participants have registered from all parts of the country. 30 foreign faculty are participating to share them expertise. Several noted Indian experts too are participating as invited speakers. The global explosion of knowledge in HIV/AIDS continues to flood the media, the Internet and the journals. Unfortunately, many of the HIV/AIDS workers in India, at grass root levels, do not have the means or access to tap this information and continue dedicated service, often in isolation. The Department of Experimental Medicine, in the TN Dr. M.G.R Medical University, is acutely conscious of this and offers you AIDS India 2000 as an update in HIV/AIDS..."Education in Continuance". We hope this mutual exchange of experience and education will be a dynamic on-going process.

1999 has been a phenomenal year in the history of HIV/AIDS and has brought about revolutionary landmarks in testing techniques, alternative therapies and impressive anti retroviral drug regimens.

Preventive strategies have generated hope with vaccines both therapeutic and preventive in humans. The use of short course AZT and 2-dose Nevirapine have mercifully reduced HIV perinatal transmission in affordable terms. Sadly this has not coloured the HIV/AIDS scenario in India. There is no suggestion of any decrease in the incidence of HIV/AIDS in India. It is estimated that the prevalence rate in the reproductive age group is 2.0 to 2.5% and rising. The task of containing HIV/AIDS in the one billion populated sub continent of India, with education, diagnosis, treatment and prevention is an enormous challenge. It cannot be done alone, singly or in isolation. There has to be unconditional co-operation strengthened by political will to fight this horrendous epidemic. Exchange of ideas, experience and expertise is imperative.

This conference , its sessions and satellite workshops are designed with young health care professionals in mind including administrators, policy makers, doctors, nurses, sociologists, behaviour scientists and others both in Government and non-governmental organisations.

Dr.N.M.Samuel
Organising Secretary

FINAL PROGRAM

SATELLITE SYMPOSIA

SUNDAY DEC 5th 1999

PROGRAMME:

08.00 A.M - 08.45 A.M Registration

08.45 A.M - 09.45 A.M Opening Ceremony

Inauguration of the Satellite Symposia

- **Dr.K.Ananda Kannan (President)**

WORKSHOPS:

I HIV Clinical Management Training Programme – Samavesh Hall

Chairs : Stefano Vella, Sankaran, Jayakar Paul

II Funding Oppurtunities from International Organisations - Sandesh Hall

Chairs: Koen Rompay and Bimal Charles.

III Issues in Perinatal Transmission – Harappa Hall

Chairs: Phadke, Catherine Peckham,Grace John

IV Safe Blood - Vedika Hall

Chairs: Indira Hewlett, K.M.Radhakrishnan, Shoba Sehgal.

HIV CLINICAL MANAGEMENT TRAINING PROGRAM

ORGANISED BY

INTERNATIONAL AIDS SOCIETY (SHARE)

&

2nd INTERNATIONAL CONFERENCE ON AIDS INDIA 2000

Dec 5th 1999

08.00 A.M - 09.00 A.M	Registration
09.00 A.M - 09.45 A.M	Welcome - **SAMUEL** Objectives of the Share Programme **- STEFANOVELLA** Felicitation **- JOSHI, NACO** Inauguration of the workshop **- Dr. K. ANANDA KANNAN**
10.00 A.M - 10.30 A.M	HIV Epidemiology : Current Status And Trends - **- LARS.O.KALLINGS**
10.30 A.M - 11.00 A.M	HIV Pathogenesis and Update **- MARK WAINBERG**

11.00 A.M	- 11.30 A.M	Coffee Break
11.30 A.M	- 12.00 A.M	Diagnostic techniques and relevance of viral load assays. **- SAMUEL**
12.00 A.M	- 12.30 P.M	Management Of Opportunistic Infections In India **- JAYAKAR PAUL**
12.30 P.M	- 01.00 P.M	Managing Opportunistic Infection In Indian Sub Continent- Bacterial And Fungal Infections **- SANKARAN**
01.00 P.M	- 01.30 P.M	Lunch
01.30 P.M	- 02.00 P.M	Managing Opportunistic Infections - Mycobacterial Infections **- ALAKA DESHPANDE**
02.00 P.M	- 02.30 P.M	Principles Of Therapy and Current Guidelines of ART **- STEFANO VELLA**
02.30 P.M	- 03.00 P.M	Management Of Paediatric HIV Infections **- CATHERINE PECKHAM**

03.00 P.M	- 03.30 P.M	HIV Resistance Drug (Holiday) and Salvage Regimens **- HANS JAGER**
03.30 P.M	- 04.00 P.M	Tea Break
04.00 P.M	- 04.30 P.M	MTCT - New trends **- MARK MIROCHINICK**
04.30 P.M	- 05.00 P.M	Post Exposure Prophylaxis **- STEFANO VELLA**
05.00 P.M	- 05.30 P.M	Question/Answers
05.30 P.M	- 06.00 P.M	Conclusion/Distribution Of Certificates

7.30 P.M - 09.00 P.M **Faculty Meeting** - SANDESH HALL

CONFERENCE AGENDA

December 6th Monday

8.00 – 9.00 a.m. - Registration

9.05– 10.30 a.m. **Plenary Session I – Samavesh Hall**

Chairs : Sankaran JR
Mark Wainberg

1. International Perspectives on the HIV/AIDS Epidemic in India.
   - Lars O Kallings
2. Building a nationwide HIV/AIDS Programe in uganda
   - Peter.N.Mugyenyi
3. Changing Prevention Paradigms for Developing Countries
   - Samuel.N.M.
4. Therapeutic advances in the treatment of HIV disease – When to start – What to Use – When to change – When to stop and when to re-start.
   - Stefano Vella
5. New findings in mother to child transmission.
   - Mark Mirochnick

10.30 - 11.00a.m. - Coffee

11.00 – 12.00 Noon - Inaugural Ceremony of the
2nd International Conference on AIDS India 2000
Hon'ble Arcot N.Veeraswami
Pro-Chancellor & Minister for
Health & Electricity

12.30 P.M - 03.00 P.M Lunch, Poster Display & Discussion

03.00 P.M - 05.00 P.M **Parallel Workshops**

I. Epidemiology & Molecular epidemiology - *Harappa Hall*

Chairs : **Roger Bernard**
Ursula Dietrich

Speakers

Roger Bernard : **Current Global HIV scenario.**

Galindez : **Molecular Epidemiology of HIV-I in Spain and In the World.**

Allauddin : **Realistic overview of Preventive Strategies in Tamil Nadu.**

Ursula Dietrich : **Primary resistance in HIV disease.**

Kozlov.A : **HIV Transmission in Eastern Europe**

Parida.S.K : **Seroepidemiological prevalence of HIV and the risk behaviour of Indian workers in Brunei**

Discussants : **Kozlov and Saple**

II. Opportunistic Infections and Prophylaxis – *Samavesh Hall*

Chairs : **Joshi**
Alka Deshpande

Speakers

Atul Patel : **Indian perspectives of anti-retroviral treatment.**

Alka Deshpande : **Prophylaxis of co-infections.**

Abraham.O.C : **What we have learnt in the last two years in the Management of oppurtunistic infections.**

Datta.M : **DOT Plus - implementation in the era of HIV/AIDS**

Rajsekaran S : **Trends of HIV Infection in patients with Tuberculosis in Rural India**

Phadtare : **MDR Tuberculosis in HIV infections - Indian Scenario And Management .**

Discussants : **Sankaran J R and Shobha Sehgal**

III. Management of HIV/AIDS in India -Sandesh Hall

Chairs : **Hans Jager**
Gourie Devi M

Speakers

Mark wainberg : **New guidelines for HIV suppression - can the 184V mutation have clinical benefit !**

Biswas J : **Ocular manifestations in HIV/AIDS.**

Gourie Devi M : **CNS Manifestations in HIV Disease**

Balasubramanian N : **Obstetric care of HIV positive women.**

Pujari S : **Management of opportunistic infections in Pune.**

Maniar : **Management of HIV/AIDS in a teaching hospital in Mumbai.**

Discussants : **Mridula Phadke, Jeyakar Paul and Stefano Vella**

IV. Behaviour youth and sexuality – Hampi Hall

Chairs : **Anjali Gopalan**
Parameshwari

Speakers

Krishnamurthy P and Lakshmibai : **Promotion of responsible reproductive health behaviour in the youth**

Anjali Gopalan : **From the cradle to the bed : The unmapped territories of youth and Sexuality**

Jacob John. T : **Psychosexual problems in Indian Youth**

Amanda Murphy : **Victim or Virgin**

Discussants : **Koen Rompay, Sathyanathan & Richard Potman**

V. Religion, Ethics & Culture - Vedika Hall

Chairs : **Shyam Prasad K M**
Donald Messer

Speakers

Joretta.L.Marshall : Caring for the Community in times of AIDS

Religions approach to HIV/AIDS education and Prevention

Hindu approach : Swamy Jnanaswaroopanantha

Muslim approach : Abdul Rahim A

Christian approach : Rev.N.G.Mathew

Donald Messer : Love,relationships,forgiveness and Healing

Discussants : **Asir Ebenazer and Balasubramaniam**

7.00 – 7.30 pm - Inauguration of AIDS Society of India - Samavesh Hall

7.30 – 9.00 pm - Dance recital and Banquet - Samavesh Hall

December 7th, 1999 (Tuesday)

09.00 A.M - 10.30 A.M **Plenary Session II – Samavesh Hall**

Chairs : **Anandakannan K**
Stefano Vella

I. **Immunopathogenesis of HIV disease including factors influencing HIV infection.**

I. **Savitha Pahwa**

II. **Management of co-infections in HIV/AIDS.**

II. **Hans Jager**

III. **Tuberculosis – HIV interactions.**

III. **Anton Pozniak**

IV. **Realistic approach for control of STDs in India.**

IV. **Rama Subramaniam**

V. **New Approaches to the Prevention of Paediatric Infection**

V. **Catherine Peckham**

10.30 A.M - 11.00 A.M. **- COFFEE**

11.00 A.M - 11.30 A.M **Prof.(Dr) Lalitha Kameswaran's Oration**
"Global challenges in the war against AIDS"
---- Mark Wainberg
President, International AIDS Society &
Director, McGill AIDS Center, Canada

11.30 A.M - 01.30 P.M — **Plenary Session III – Samavesh Hall**

Chairs : Dorothy Bray
Kozlov A

Speakers

I. "A Vision" on HIV Prevention

- Deborah.L.Birx

2. Anti retroviral therapy in resource poor settings.

I. Joep Lange

3. Immune modulation in HIV infection.

II. Mario Cleriche and Dorothy Bray

4. Strategies to eliminate deep seated Prejudice against those infected and affected With HIV/AIDS.

- Ashok Pillai and Geetha Venugopal

5. Need for nutritional interventions in Indian setting for HIV disease

- Sai Subhasree Raghavan

01.30 P.M - 03.00 P.M — Lunch, Poster Display & Discussion

03.00 P.M - 04.30 P.M — **Parallel Workshops**

I. HIV/AIDS Impact on Development - Samavesh Hall

Chairs : Subhash Hira
Lars O Kallings

Speakers

Peter.N.Mugyenyi : Coping with HIV/AIDS in Subsaharan Africa

John.P.C : Poverty,inequality and AIDS

Sunny Mahajan : Impact of HIV/AIDS on economic Development

Balasubramaniam	**: Economic impact of HIV on "transportation systems"**
John.K.R	**: Impact of HIV/AIDS on Care Systems in India**
Yasmin Halima	**: Optimising care for people living with HIV : Human, economic and Therapeutic strategies**
Lars.O.Kallings	**: Facing the third millennium-Long time impact of HIV/AIDS**
Discussants	**: Bimal Charles and Rajendran**

II.STD/HIV Laboratory Diagnostic Techniques **– *Vedika Hall***

Chairs	**: Sridharan G Mini Jacob**
Speakers	
Milton Tam	**: Recent developments in the diagnosis of sexually transmitted diseases.**
Subash Hira	**: To integrate HIV and Sexually Transmitted Disease diagnostics for use in India.**
Sue Best	**: The utility and complexity of HIV-1 viral load quantification.**
Mini Jacob	**: Potential benefits of pooled sera technique in screening of HIV.**
Neil Constantine	**: Recent advances in HIV diagnostics and improved Strategies for testing.**
Discussants	**: Srikanth.P.Tripathy and Nalini Ramamurthy**

III. Megacities Vulnerability, IVDUS/ STD/HIV - Harappa Hall.

Chairs	**: Suresh Kumar and Ganesh**
Speakers	
Banerjee K. L	**: Epidemiology of HIV infection from the West Bengal Perspective**
Suresh Kumar	**: Dilemmas of Intervention Strategies**
Anjali Gopalan	**: The urban jungle : The Hidden World of Vulnerabilities.**

Jerajani R N : Harm reduction Programmes for IVDUS in India

Gilada.I.S. : Providing Services in megacities

Saraswathi Sankaran : Vulnerability of industrial Labour

Discussants : Shivashankari , Grace John and Uzgare

IV. HIV Vaccines - Sandesh Hall

Chairs : Vinayak
MacElrath J

Speakers

Ramesh.S.Paranjapee: CTL Responses in HIV/AIDS patients

Julie MacElrath : HIV vaccines - understanding the successes and failures.

Deborah Birx : Immune Response and Immune reconstitution in HIV/AIDS

Discussants :Deborah Birx , Ramesh.S.Paranjapee and John McNeil

V. Free Presentaion -- Hampi Hall

Chairs: Krishnamurthy
Ganga Khedkar

1. **Zafrulla** - Attitude and practice of Registered Indian Medical Practitioners in treating STD patients.

2. **Chacko T** - AIDS Awareness among health care providers in a teaching hospital in Coimbatore.

3. **Prakash J** - A case of triple retroviral infection with HIV-1 genotype C3,HIV-2 and HTLV-1.

4. **Alamelu C** - Diagnostic value of measuring IgG antibody to Lipoarabinomannan (LAM) antigen in patients with Pulmonary tuberculosis.

5. **Vijaya Srinivasan**- Micro mapping technique as a method of HIV surveillance.

6. **Sekar** - Life style of Enuchs

7. **Mary S** - Problems encountered in working with seropositive pregnant mothers.

8. **Edwin Amalraj**- Knowledge in sexual practices among the youth.

04.30 P.M - 06.00 P.M **Special Plenary Session IV - Samavesh Hall**

Indian Systems of Medicine - Siddha

Chairs **: Deivanayagam C**
Anandkumar A

Speakers

Deivanayagam C **: Current status of Siddha Drugs in HIV infection**

Jayaprakash Narayanan **: The role of Siddha medicine in the management of HIV disease**

Kesavan M **: Ayurvedic Therapy in HIV/AIDS**

Soundarapandian K **: Siddha Medicines in HIV disease and a comparison with Allopathic drugs.**

Lakshmi R **: Siddha System of Medicine in AIDS**

Discussants **: Alka Desphande and Mark Wainberg.**

December 8th 1999

09.00 A.M - 10.30 A.M **Plenary Session V- Samavesh Hall**

Chairs : **Banerjee K**
Sunithi Solomon

1. **Resource mobilisation for testing, AR Drugs and Vaccines.**

   - **Sunithi Solomon**

2. **Women need microbicide activism to combat HIV/AIDS**

   - **Mark Wainberg**

3. **AZT/Nevirapine – What's in it for the Indian mother and the infant**

   - **Dorothy Bray**

4. **Post-exposure Prophylaxis and Management**

   - **Chandrasekaran**

5. **Setting global coalitions between Drug industry and Developing countries to Reduce HIV burden by anti-retrovirals**

   - **Carl Pommer.**

10.30 A.M - 11.00 A.M **Coffee Break**

11.00 A.M - 01.00 P.M **Plenary Session VI – Samavesh Hall**

Chairs : **Somasekaran V**
Joep Lange

1. **Chronic toxicity of anti-retroviral agents**
   - Joep Lange

2. **Syndromic approach for control of HIV/AIDS in India**

   - **Ganga Khedkar**

3. **Unanswered critical policy issues-Right of the health care workers,mandatory testing and post exposure prophylaxis**

   - **Murali.N.S**

4. HIV – Occupational hazard for Health Care Worker

- **Rajkumar**

5. Needle Stick injury registry

- **George M Chandy**

6.Human rights and Ethical issues in HIV/AIDS Disease

- **Anand Grover**

7. <u>Panel Discussion - Guidelines</u>

- **Vijaya Lakshmi Acharya,Vijaya Kumar and Jawahar**

01.00 P.M - 02.00 P.M **Lunch, Poster Display & Discussion**

02.00 P.M - 03.30 P.M **Parallel Workshops**

<u>1. MTCT</u> – Sandesh Hall

<u>Chairs</u> **: Cipriano Canosa**
Savitha Pawha

<u>Speakers</u>

Dorothy Bray **: Global Overview of MTCT studies.**

Nafees Ahamed **: Pathogenesis of HIV-1 infection in mothers and infants.**

Koen Rompay **: Evaluation of therapeutic,prophylactic and safety profile of the noval anti-HIV drug PMPA in infant macques**

Parameshwari **: Administration of AZT to unregistered mothers prior to Caesarian section.**

Mark Mirochnick **: Nevirapine - a new strategy to prevent mother to child Transmission.**

Merchant **: Challenge of paediatric management.**

<u>Discussants</u> **: Catherine Pechkam and Mathai Mathews**

II. Safe Blood - Hampi Hall

Chairs : **Ishwar Vishweshwar**
Indira Hewlett

Speaker

Ramalingam Vimala : **Blood banks and Transfusion Services in India**

Dolly Rose : **Are we assured of safe blood?**

Indira Hewlett : **Safe blood as a strategy to contain HIV infections.**

Rema Menon : **Problems encountered in blood donors.**

Jaju N.B : **Transfusion induced HIV infection in India**

Discussants : **Deborah Birx and Radhakrishnan**

III. Counselling and Confidentiality – Vedika Hall

Chairs : **Pratap Thariyan**
Joretta L Marshall

Speakers

Pratap Thariyan : **Cultural issues affecting counselling, confidentiality and Informed consent.**

Arthi S : **Dilemmas of an obstetrician at a rural clinic.**

Ashok Pillai : **Living with Discrimination.**

Anand Grover : **Right to information.**

Discussants : **Shyamala Natarajan and Zafrullah**

IV. HIV Care and Services – Harappa Hall

Chairs : **Jayakar Paul**
Atul Patel.

Speakers

Saple D G : **Specific medical needs of HIV/AIDS Patients and their Families**

Daisy Dharmaraj : **Developing a Community based HIV/AIDS Programme.**

Manoharan G : **From Prevention to HIV/AIDS in a rural setting.**

Manorama : **Can Indian women with HIV/AIDS evaluate their own needs ?**

Heidemarie Kremer : **Empowerment for women from women through community Advisory Board (CABs)**

Discussants : **Manoharan and Banerjee K**

V. NGO and Community's Response to HIV/AIDS- Samavesh Hall

Chairs : **Jacob John T**
Gilada I S

Speakers

Gilada : **The roles of NGO'S and the Community to formulate Realistic strategies to prevent a crisis in the next Century**

Krishnamurthy P : **Targeted intervention for HIV/AIDS prevention – The need of the hour.**

Amanda : **A postive Response by a local business Community**

Constance Blowers : **Public and Private sector partnerships as an effective mechanism for addressing HIV/AIDS issues.**

Discussants : **Suresh and Ashok Pillai**

3.30 - 4.00 p.m : **Coffee Break**

4.00- 5.00 p.m. : **Closing ceremony – Presided by Dr. K. Anandakannan**
Presentation of awards
Chennai Statement

INVITED LECTURES

INTERNATIONAL PERSPECTIVES ON THE HIV/AIDS EPIDEMIC IN INDIA

Lars O Kallings

In an international perspective, HIV/AIDS arrived late to India. From an estimated number of a few thousand HIV- infected persons in the early 1990s, there are now at least four milion people living with HIV/AIDS in India. This means that India today has the highest absolute number of infections in all countries of the world. In comparison, China-as another one bilion-population country-has an estimated 400,000 HIV-infected persons. However, in a global comparison, sub-Saharan Africa, with 9% of the world population, harbours two thirds of the global total of HIV infections, while Asia and the Pacific, with 60% of the population, carry 20%- at least 6.5 milion-people living with HIV/AIDS.

As in most countries, India has several HIV epidemics with different patterns and prevalence. The epidemics vary significantly from state to sate. Heterosexual transmission is predominating in e.g. Maharashtra and Tamil Nadu, whereas HIV infections associated with injecting drug use is most common in Manipur. In general, there is a comparatively high HIV prevalence in western and southern India and low levels in the eastern and northern parts of the country. This heterogeneity together with big differences in social structures and the enormous size and population of the sub-continent, make it particularly difficult to monitor the various epidemics and institute effective interventions. This has probably contributed to the rapid and continuing spread of HIV in India despite the ten-year grace period India experienced from the start of the extensive spread of the HIV/AIDS epidemic in western countries and in Africa in the early `80s until the prevalence rose abruptly in India.

Globally, the epidemics linked to different modes of risk behaviour seem to exist independently of each other without much interaction; one of the best examples is the parallel epidemics in Thailand-two epidemics caused by HIV-1, subtype B in men who have sex with men and in injecting drug users and a third major epidemic caused by subtype E in the heterosexual population. In India subtype C seems to be predominating.

In Asia, including India, the frequent male use of female sex workers, together with migration patterns, seem to be the main risk factors fuelling

the heterosexual epidemics. This has resulted in a prevalence of 2-3% HIV - infections among the total 15-49 year-old population in several states in India, as well as in Cambodia, Myanmar and Thailand.

Among injecting drug users a prevalence of above 50% occur, in Northeast India as well as in several provinces of China, in Malaysia, Myanmar, Nepal and Vietnam and also in many parts of the former Soviet Union. HIV is spread, not only by injecting equipment, but also from drug users to sexual partners.

The continued development of the HIV/AIDS epidemics in India is of major global concern due to the size of the population and the central role that India plays in the region.

THE HIV/AIDS SITUATION IN UGANDA

Peter Mugyenyi

The first case of AIDS was reported in Uganda in 1982 in the south of the country. Since then, more cases have been reported and HIV/AIDS has assumed epidemic proportions to become one of the major public health problems of our time. Because of its unprecedented impact on individuals, families, communities, economy and national development as a whole, HIV/AIDS prevention, control and research has become a priority concern of Government.

"The strong political commitment and leadership led to setting up of organs like the Uganda AIDS Commission in 1992 to facilitate coordination in the implementation of the multi sector AIDS control strategy. AIDS Control Programs under the Ministry of Health and other line ministries were also set up to effectively address the epidemic. A surveillance system and various interventions have been implemented to control the spread of HIV infection. These efforts have resulted in 90-95% level of public awareness on the disease, adoption of risk reduction behavior, break down of stigmatization and a decline in rates of new HIV/AIDS cases. Programs providing supportive and terminal care have also been implemented. PWAs have formed associations to provide mutual support and educate the community on the impact of the epidemic. The search for medical care has increased demands to avail affordable antiretroviral drugs and treatment for opportunistic infections and has increased the strain on the health facilities.

For effective prevention and control, a lot of research has been undertaken with support from various donors in the fields of prevention, epidemiology, socioeconomic, clinical, basic sciences and behavioral issues related to HIV. This has generated enormous data with significant or potential relevance both positive and negative to the current national policy and plan development strategy.

Uganda's success in fighting HIV has been dependent upon a high degree of collaboration and cooperation between government, NGOs, community-based organizations, religious organizations, private sector and external support agencies. Since a cure and a vaccine for HIV are not yet available, control of the epidemic has been achieved by intensifying and sustaining existing interventions.

CHANGING PREVENTION PARADIGMS FOR DEVELOPING COUNTRIES

Samuel NM

The steps In an attempt to eradicate any Infectious disease must Identify the disease, learn about the disease, treating the disease and protecting against the disease. All this must be done simultaneously as high priority not one against the other.

HIV was recognised much later in India than in the rest of the world. The country's achievements in the field of development and health may be threatened If this epidemic is not contained. A mature epidemic has it's own sequelae as observed in other countries -increase in health care costs, decreased life expectancy

and Increase in infections which decrease the life span of the Infected.

Since HIV was detected in 1985/86 in India, Prevention strategies were given priority as this is certainly the best way to halt any Infectious disease. However, in the second decade of this infection, there is a need to reconsider our priorities.

- There Is a need to Introduce HIV as a subspeciality In medicine as it is a multi system disease presenting in any OPD be It medicine, surgery, OBGY or paediatrics.
- There is a need to Invest in training of the health care community In care of the Infected and the affected. Hospitals ought to treat the HIV infected like any other infectious disease.

- There is a need to reduce transmission in the community.
- The prevalance of MTCT ranges between 1-4% In India. It Is now possible to reduce MTCT upto 50% -60% when drugs costing Rs.160/- are given to a pregnant mother.
- There is a need to introduce anti-retroviral drugs to most in need -the priority being women and children.
- There is a need to make Tuberculosis control a national emergency and committed innovative programmes need to be Implemented where the community has a major role In it's prevention.

There is a need to look into our culture, folk lore and tradition to learn from them as to find "Cure" and bring them Into the main stream of our intervention.

- There is a need for us to invest in HIV prevention, Vaccine, it's development and production.
- To achieve these steps a collaborative approach of all sectors of society is needed to make this paradigm shift a reality.

THERAPEUTIC ADVANCES IN THE TREATMENT OF HIV INFECTION

Stefano Vella

Between 1996 in 1999, the availability of potent antiretroviral therapy has had a dramatic impact on the natural history of HIV, with unprecedented changes in disease progression and mortality. However, despite the impressive progress to date, much work remains to be done. Even with the most potent regimens available today, there exists a significant proportion of patients who fall to have a complete response after their first line treatment and is at high risk of experiencing a virologic rebound, and will be less and less responsive to subsequent antiretroviral regimens.

Incomplete response rate and limited durability of the response are not the only shortcomings of the current regimens, with other problems including complexity, toxicity, cross resistance among drugs of the same class, unfavorable pharmacokinetics . These problems are particularly evident in patients with high plasma HIV-1 RNA levels, extensive prior treatment, and advanced disease.

Data from several studies indicate that the nadir of the virologic response and the rapidity with which virus replication is shut down are strongly predictive of the likelihood of achieving a durable virologic response. The available data suggest that little or no virus evolution occurs in the residual virus population when plasma HIV-1 RNA is presistently suppressed to below the limits of quantification of ultrasensitive assays.

To achieve the goal of a complete suppression of HIV in plasma, at least in subjects at their first antiretroviral treatment, several strategies are now available. These include protease inhibitor (PI)-containing and PI-sparing regimens, which include potency, extensive experience, evidence for long term durability, potential exploitable drug-drug interactions, widely known toxicity profile, evidence of effectiveness in patients at all levels of plasma HIV-1RNA. Nevertheless, important disadvantages may limit their acceptability, including the complexity of the regimens, cross-resistance between different PIs the growing concern over long-term toxicities (including fat redistribution, and lipid abnormalities with unknown effects on long term cardiovascular morbidity and mortality). For these reasons, and with the availability of new potent inhibitors of reverse transcriptase, PI-sparing regimens have been introduced into clinical research initially, and clinical practice thereafter. In this context, non-nucleoside reverse transcriptase inhibitors (NNRTI) have gained in popularity because they may defer PI usage and allow for a lower pill daily burden. On the other hand they are not without potential disadvantage. Among these, resistance issues represent the main cause of concern, together with the lack of exhaustive information about long term efficacy. Recently the possibile use of triple NRTI therapy as a PI-and NNRTI-sparing regimen has been proposed. Most data refer to the combination of abacavir, zidovudine and 3TC, which has resulted in durable (48-week) virologic responses. As with the NNRTIs, the main attraction of an all-NRTI regimen is the deferred usage of PIs, while also sparing the NNRTI and placing only a single class of agents "at risk" for development of resistance. However, also in this case, the long-term antiviral potency/efficacy and toxicity of multinucleoside regimens are unknown. With short-term clinical trials indicating comparable potency of PI-NNRTI-and all NRTI-containing regimens, the attention should be rather focused on their differences with regard to long term outcome, toxicity, constraints on future regimens, and the effect on viral reservoirs. The answers to these questions and the advantages/disadvantages ratio of these different treatment strategies will only come from the results of will- controlled strategic clinical trials. In spite of the huge advances in antiretroviral therapy, we are still far from having

TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY • CHENNAI • TAMIL NADU
HEALTH FOR ALL

solved the problem of HIV infection. In fact, currently available regimens have limited potency and remarkable toxicity. Furthermore the high number of theoretical combinations is only apparent, since, cross reactivity among drugs of the same class makes the actual number of therapeutic options rather limited. Better drugs, safer and easier to administer, with more favorable pharmacologic properties and activity against drug-resistant viruses are therefore needed.

The validation of drug resistance testing for use in clinical practice will provide clinicians with a helpful tool for patients' management and salvage therapies will hopefully be designed on the basis of individual resistance profiles, allowing for more specific treatments.

Unfortunately, we cannot underscore the fact that impressive therapeutic gains in the management of HIV disease benefit only 10% of the HIV infected global population. For the remaining 90%, effective vaccination, although still far from being available despite remarkable progress, is the only approach that is likely to have a major 6effect on the AIDS epidemic in the developing world.

NEW FINDINGS IN MOTHER TO CHILD HIV TRANSMISSION

Mark Mirochnick MD

One of the most important advances in combating HIV infection has been the development of effective methods of reducing mother to child HIV transmission. A regimen of AZT administered during pregnancy and labor to the mother and for 6 weeks after birth to the infant decreases the risk of transmission by two-thirds. Transmission can be further reduced through the use of multidrug antiretroviral regimens or by scheduled caesarian section before rupture of membranes. These approaches are currently being used in North America and Europe, and the rate of mother to child HIV transmission is falling dramatically in these regions. Less intensive regimens, with shorter periods of drug administration, are less effective but may be more practical in areas where health care resources are scarce. A two dose nevirapine regimen (consisting of a single oral maternal dose during labor and a single oral infant postnatal dose) has been shown to reduce transmission by 50% compared to an equivalent AZT regimen. We now have practical and effective means to reduce mother to child HIV transmission. The difficult challenge that remains is identifying HIV infected pregnant women and providing these therapies to them.

PAST & CURRENT GLOBAL HIV SCENARIO: METHOD AND OUTCOME (AF 12 99)

Bernard RP

Background

11 years work with AIDS(GOV.Survcillance) and HIV (GPA / WHO / UNAIDS Estimates) is the frame work of this review.

Materials

Official figures/series are used throughout.

Methods

Global Analytical Integration (GLANIN)passing through 6 evolutionary phases: a)AIDS case Rates (/ 10^5) for patterns by country and Global annual birank review (green:1990-96), b)10-year TREND reviews by region/country, c) Reconstruction of mid-1980s (minimal) HIV incidence with 1996 AIDS Case rate at GEO-2/3 specificities for France/Spain/Argentina/Brazil/USA, d)World Map of Adult HIV PREV (ISPMZ/AF/UNAIDS) in 8-level/factor-4 colour grouping, e) DEM-EPI display (surface) OF 3-REGION HEMISPHERE-WEST I end-1997 Adult HIV Prevalence (RIO)-2; HEMISPHERE-EAST for UNFPA South-South Project (NANJING), f)DEM-EPI Display of late 1990s HIV-Incidence; HIV/AIDS-Prevalence & their relationships: Recent Dynamics of HIV Spread (4-Author for 12th World AIDS conference Geneva mid-1998) and Ist update Oct.1999: SOUTH-NORTH HIV-SPREAD GAP:NOW (ICAAP- 5, Kuala Lumpur, 23-27 Oct.1999).

Results

Developed with on the job above method development.

Conclusion

Rigorous method development leads in December 1999 to a WORLD RISK WEB of NEW HIV INFECTIONS & PARALLEL PREVALENCE.

MOLECULAR EPIDEMIOLOGY IN SPAIN AND IN THE WORLD

Cecilio Lopez-Galindez, Concepcion Casado, Victor Sanchez-MerinoHIV-1

genetic variability has been successfully exploited for genetic characterization of field isolates and in Molecular Epidemiology studies. Since its definition, genetic subtypes has been very helpful for the study of the HIV-1 epidemic in the world where subtypes C, A and B are the most prevalent. Recently the contribution of recombinant strains has been established in the epidemic of countries where different subtypes cocirculate.

Different methods has been used in the characterization of the HIV epidemics. Serologic tests by peptide ELISA has been used for the screening of large number of samples although they present some difficulties in the discrimination of some subtypes. At the genetic level, screening methods like RNase A mismatch method and Heteroduplex mobility assay offers the possibility of analyzing multiple samples. However nucleotide sequencing coupled with phylogenetic analysis is the most informative technique although it cannot be applied to many samples.

In Spain, we have one the most important epidemic in Europe with 50 000 AIDS cases and estimations of around 120000 infected individuals. We have studied the epidemic in different works using techniques like ELISA peptide serology, RNase A mismatch method, Heteroduplex mobility assay and nucleotide sequencing. As a summary, HIV-1 epidemic in Spain has been caused by subtype B viruses with a very minor circulation of other subtypes (1). We did not detected any genotypic difference between the viruses in different risk groups in contrast with what occurs in other European countries (2). We have also established that there is a progrossive divergence of isolates of 0.49% per year (3).

In a program coordinated by UNAIDS we have studied subtype C viruses from different countries Brazil, China, India, Israel and South Africa. The viruses were culture negative samples and they where analysed by nucleotide sequencing in gag and env genes. We have been established the phylogenetic relations among the isolates and concluded that there is a clustering of isolates by countries. China and India isolates

clustered in the same phylogenetic branch. We have also detected the presence of one B/C recombinant among the India isolates.

In summary, different techniques could be helpful in Molecular Epidemiology studies. These data suggest the importance of founder effects in the HIV-1 epidemic.

References

1. Rojas et al, 1994 Virus Research 31:331.

2. Casado et al, AIDS Research and Human Retrovirus in press

3. Casado et al, JAIDS, submitted.

REALISTIC OVERVIEW OF PREVENTION STRATEGIES IN TAMIL NADU

Allaudin K

"Awareness is the key to prevention" declared by the PM of India. Realizing the importance of awareness, Tamil Nadu launched intensive campaign using mass media folk medium etc. from 1994-95. The awareness among various sub- population groups has increased to nearly 98%. The awareness level even in rural areas of Tamil Nadu is better as compared to even urban areas of some other States.

As part of prevention efforts, intervention programmes have been taken up through NGOs. They are working among CSWs, Truckers, MSMS, Migrant workers and other vulnerable groups. This has helped to promote safe sex, treatment seeking for STDs, reduction in non-regular sexual partners etc. which have in turn helped prevent infections.

The facilities for treatment of STD have been improved and out reach services extended to villages. Free supply of condoms along with unique social marketing programme implemented with the help of condom manufacturers has helped improve distribution, sale and use of condom.

The strengthening of Blood Banks through licensing and mandatory testing of blood before transfusion have helped prevent transfusion

related infection. The Voluntary Blood Donors Clubs in the colleges and rural areas have been useful in making safe blood available easily.

The training and orientation of field staff in prevention and control of HIV/AIDS has been useful in equipping them with necessary knowledge and skills and disseminate the same to the public. The advocacy workshops for the panchayat leaders, opinion makers and introduction of HIV/AIDS education in colleges and schools have gone a long way in involving the entire community in prevention and control of HIV/AIDS.

Tamil Nadu's experience in implementing prevention activities through the Society is unique and has evolved as a model for rest of the country. The prevalence of HIV/AIDS among STD clinic attendees is pla teaming and stands at 16.27% in September 99 while the prevalene among TB patients fluctuates between 4.39% & 9.6% . Among the AnteNatal mothers, the prevalene is fluctuating between 0.69% and 1.63%. The available data indicates that the preventive efforts in Tamil Nadu are becoming a success and the rate of infection will come down sooner than later.

PRIMARY RESISTANCE IN HIV-DISEASE

Dietrich U*, Raudonat I*, Knechten H, Jaeger H, Husak R, Samuel NM, Immelmann A

*Georg-Speyer-Haus and Analysis GmbH, Frankfurt, Germany; PZB, Aachen, Germany; KIS, Muenchen, Germany; Klinikum Benjamin Franklin, Berlin, Germany; The TN Dr. MGR Medical University, Chennai, India.

Background

The introduction of early antiretroviral combination therapy in Western countries has lead to clinical improvement, reduced viral load and higher CD4 numbers in HIV-positive persons. However, broad and long lasting treatment with a number of antiviral drugs may also lead to the accumulation and transmission of drug-resistant HIV-strains.

Objective

To study the presence of resistance mutations for protease inhibitors (PI) in 95 therapy-naive HIV-1 positive Germans before and after introduction of PI by direct sequencing of PCR products derived from the pol region.

Untreated HIV-positive persons from India, where antiretroviral treatment has not been introduced to the same extent, were included in the study.

Results

In German patients protease-resistance mutations increased from 35.3% in samples obtained before introduction of PI (1994,1995) to 56.8% after introduction of PI (1996,1997). Also the number of protease resistance mutations per sample increased from 1.35 to 1.69 before and after introduction of PI, respectively.

In three cases, where the index partners for HIV-transmission were known, we detected identical resistance mutations for protease inhibitors in the donor and the recipient suggesting indeed transmission of drug-resistant strains. Transmission of resistant viruses is further supported by the very close relationship of V3- sequences derived from donors and recipents.

5 out of 10 untreated Indian patients had a resistance mutation at codon 36 of the viral protease confering low level resistane to ritonavir and nelfinavir. This seems to be a frequent natural polymorphism in HIV-1 subtype C viruses. No other resistane mutations were observed except for I patient who was muatntat position 10 of viral protease.

Conclusions

Our data point at increasing prevalence of resistance mutations for protease inhibitors in untreated HIV-1 positive Germans since the introduction of PI. Increased prevalence may be due to not fully suppressive virus inhibition and transmission of drug-resistant HIV strains. Some HIV-1 subtypes may carry natural polymorphism leading to reduced sensitivity to certain antiviral drugs.

HIV TRANSMISSION IN EASTERN EUROPE

Kozlov Anderi Pertrovich

There have always been differences in HIV epidemic trends between Eastern and Western Europe. Until mid- nineties, countries of Eastern Europe constituted the low prevalence area, in contrast to the West. In the West, the annual AIDS incidence started to decline since 1995. At nearly the same time a sharp rise of HIV incidence among IDUs was observed in the former Soviet Union republics especially in Ukraine, Belarus, and Russia. This was preceded by a relatively safe period. In Russia, where the first HIV cases were detected in 1987, the cumulative number of reported HIV cases reached only 1061 by the end of 1995. Noteworthy is that this figure was derived from a unique program of large scale screening for HIV, not from calculations based on tests performed in selected groups of population or on reported AIDS cases. Although the actual coverage is difficult to estimate, the above figure is most probably closer to reality than the UNAIDS estimate as for 1997, which was about 40000. From 1061 reached by the end of 1995 the cumulative HIV prevalence rocketed to 2556 already by the end of 1996. As for 30.06.1999, this number has reached 16330. It is still lower than in Western European countries, but the tendency is very alarming : during the first six months of 1999 the HIV incidence was 2.5 times more than that during the same period of the previous year. An especially rapid development of HIV epidemic took place in Ukraine. In 1987-1994. only 183 cases of HIV infection were deteted in Ukraine. But by the end of 1995 the cumulative number of HIV infections has reached 1673. In 1996, more than 12000 of new cases of HIV infection have been detected. So. during two years the cumulative number of HIV infections has increased almost by two orders of magnitude. Before 1996. HIV spread in these countries occurred mainly via the sexual route of transmission. 1996 was the year when HIV penetrated the rapidly increasing IDU populations of these countries. By now, IDUs are responsible for the absolute majority of newly reported HIV cases. In some localities, like Kaliningrad in Russia, Svetrogorsk in Belarus, and Nikolaev, Donetsk, and Odessa in Ukrain HIV prevalence in IDU populations exceeds 5% i.e. the epidemic has entered the Concentrated phase. The situation with HIV and IDUs in former Soviet republics is still more peculiar with regard

TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY • CHENNAI • INDIA
HEALTH FOR ALL

to HIV subtype distribution. The predominant subtype is A. The genetic homogeneity of isolates obtained in various places suggests that it originates from a point source. This looks less surprising in view of the prevalent habit of loal IDUs who inject home made drugs from one huge batch prepared using the blood of its manufacturer added to clear it from one huge batch prepared using the blood of its manufaturer added to clear it from sediments. In Kaliningrad (Russia), an A/B recombinant redominates. Its gag is highly homologous to subtype B prevalent among IDUs in Nikolaev (Ukraine). The presence of B subtype is still signifiant elsewhere in these countries (about 15%) because of its predominance in homosexually and heterosexually infected people who constituted the initial contingent of subjects infected with HIV before 1996. Other subtypes from C to H were also found and make 5% to 10% altogether.

SEROEPIDEMIOLOGICAL PREVALENCE OF HIV AND THE RISK BEHAVIOR OF INDIAN WORKERS IN BRUNEI

Parida SK

The foreign worker screening programme in Brunei started in July 1993. A total of 487 foreign workers from different countries of Asia and the Pacific were found to be HIV positive from July 1993 to August 1999. Out of these 487 HIV positive foreign workers, 49 were from India. The distribution of these 49 HIV positive workers as per their home state are : 30 from Tamil Nadu , 5 from Bombay (Maharastra), 5 from Andhra Pradesh, 3 from UP , 2 from New Delhi and 1 each from Punjab, Bihar, Kerala and Gujarat state. Out of these 49 workers. 8(16.3%) were below the age of 25 years , 37(75.5%) were between the age group of 26 to 40 years and the rest 4(8.2%) were between the age group of 41 to 50 years.

The workers found HIV positive were counseled and during the process of counseling their sexual behavior and the past history of STD was noted. Among the HIV positive Indian workers, 45 (91.8%) were infected through heterosexual transmission with commercial sex workers, 1(2 %) from blood transfusion and for rest of 3 workers the mode of transmission is unknown. When asked about the use of condom during the casual sex, 31(63.3%) replied that they never used a condom, 13

(26.5%) used sometimes, 1(2 %) used always and for 4(8.2%) the use of condom was unknown. 16.3% of the HIV positive Indian workers had the past history of STD.

This study revealed that the workers did not know the risk of HIV infection involved in casual sex with a commercial sex workers and the importance of condom use during the casual sex. Massive condom promotion programme and the social marketing of condom should be given top priority in India. Besides all the workers who want to go to a foreign country must check their blood for HIV status before leaving the country so that they will not undergo stress and strain in a foreign country after knowing their HIV positive status. These workers are paying a lot of money (up to 50 thousand rupees) to the local recruiting agents to go to a foreign country for gainful employment but were deported from the country within days of their arrival because of their HIV positive status. So HIV screening of the workers should be done in India before they seek job abroad. The recruiting agents should be informed about the problems an worker is facing in a foreign country after he is detected HIV positive. Strict law should be enforced against the recruiting agents for not sending any worker to a foreign country without being checked for the HIV status. This study could be of importance for the policy makers of the medical and health services in countries importing and exporting the workers.

INDIAN PERSPECTIVES OF ANTIRETROVIRAL TREATMENT: EXPERIENCE WITH DOUBLE NUCLEOSIDE COMBINATION ON CD 4 LYMPHOCYTE COUNT & THE INCIDENCE OF CLINICAL DISEASE IN HIV INFECTED PATIENTS WITH CD4< 500/CMM

Atul K Patel

Introduction

The major advances in HIV/AIDS therapy have been made during the last few years with combination therapy and introduction of PIs. Definitive evidence now exists demonstrating the clinical benefit associated with the use of combination therapy.

Despite substantial progress, the degree of treatment benefit conferred by different treatment strategies, there is no end to anti-retroviral treatment.

Standard anti-retroviral treatment (HAART, 2NRTI+IPI) is very costly, costing 20,000- 25,000 rupees per month.< 5% of patients can afford it. Real problems of HAART are 1) No definite end point; it has to be continued for indefinite time, probably life long.

2) Prolonged therapy with PIs causes many metabolic side effects like diabetes, hyper lipidemia, fat redistribution- these may complicate future treatment and increase risk for cardiovascular/cerebrovascular diseases.

3) PIs have drug interactions with commonly used drugs. Most important examples are rifampicin, cisapride, astemizole etc. Tuberculosis is one of the most commonly found opportunistic infections with HIV, use of PI may complicate treatment of tuberculosis.

Treatment of HIV infection with Double Nucleoside combinations i.e ZDV+3TC, d4T+ddi is not recommended by US Panel because of fear of development of drug resistance. One may get clinical beneficial

effects with 2 NRTIs for first 48 weeks but 2NRTIs cannot achieve prolonged suppression of viral load.

Patients & Methods

This open label randomized prospective study was launched to see clinical & CD4 lymphocyte response of Double Nucleoside combinations (ZDV+3TC&d4Tddi) in HIV infected patients with CD4 lymphoclyte count <500/cmm. Viral load monitoring was not done due to costfactor.

Those patients with symptomatic HIV infection with CD4<500/cmm were offered 2NRTIs. Patients' financial status was evaluated & those who could afford the drugs for more than 3 years were started with 2NRTIs.

All patients were anti-retroviral naive patients.

Patients with Hbs Ag positive serology were offered ZDV+3TC combination & patients with pretreatment anemia, leucopenia were offered d4t+ddi.

PO BID>60Kg, ddi 100mg 20D/100mg 2BID>60Kg.

After base line evaluation, all patients were evaluated clinically every monthly with detailed physical examination and necessary hematological and biochemical tests were obtained. CD4 lymphocyte counts were done every 3 monthly, enumeration of CD4/CD8 lymphocytes was accomplished by Becton Dickinson FACS Count system. Patients with CD 4 lymphocytes count<200/cmm were started with co-trimaxaole DS once daily for PCP prophylaxis.

Patients were also prescribed appropriate treatment for TB/Candida/ diarrheal illness and for other associated illnesses.

Results

Demographic characteristics, ZDV+3TC(n=32) group 24 men, 8 women, d4T+ddi (n=13) 10 men and 3 women. Median age in ZDV+3TC 34.5 years and in d4T+ddi 35 years.

Presenting illness in two groups (ZDV+3TC, d4T+ddi) were PTB(n=2,2), LNTB (n=6,3), TBM(n=0,1), OPC (n=26,7), EC(n=4,0), Diarrheal Diseases (n=5,0), ADC(n=1,0), Cerebral toxoplasmosis (n=0,1), cryptococcal meningitis (n=0,1).

Baseline CD4 Counts

	ZDV=3TC(n=32)	d4T=ddu (n=13)
<50	5	2
51-100	6	3
101-150	8	2
151-200	6	4
201-250	4	2
>250	3	-

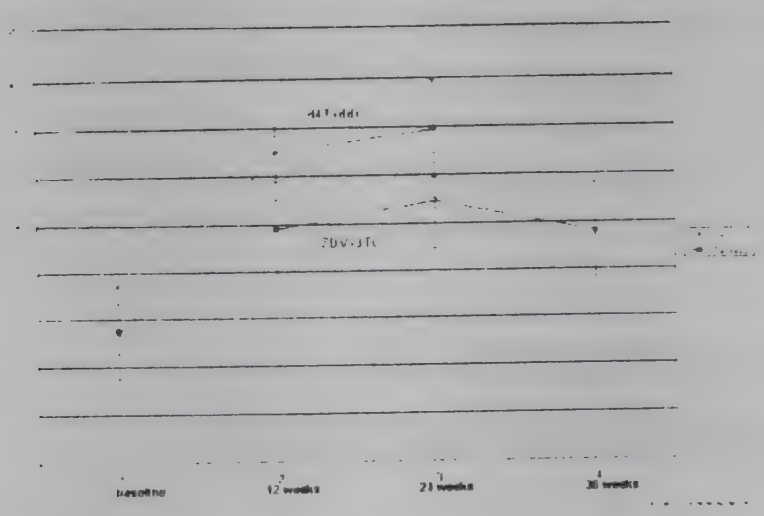
Clinical Response with treatment

4 patients receiving 2 NRTIs had single episodes of OPC, rest of the patients remained free from OPC & episodes of diarrheal illness, and showed weight gain.

Patients morale was boosted and confidence regained.

Side effects due to ART

Severe anemia requiring transfusion occurred in :3, Leucopenia : 6, Painful distal sensory neuropathy: 3, Nausea & vomiting: 7.



11 patients have completed 36 weeks of treatment with ZDV+3TC showed decline in median CD4 lymphocyte counts.

Discussion

These results are consistent with the notion that apparently beneficial changes in the peripheral blood HIV RNA level and CD4 lymphocyte count that are induced by treatment are associated with a corresponding clinical benefit.

There are limitations to the findings presented here, most notable being that findings are based on only a small number of patient treated over 24 weeks & 36 weeks. Viral load assay was not done, only CD4 lymphocyte counts were used to demonstrate response. There has been debate over whether the increase in CD4 count seen in peripheral blood after therapy is due to redistribution from lymphoid tissue or arises as a result of newly produced cells due to decreased viral load & decreased viral turn over. Our findings suggest that the rise in CD4 lymphocytes appears to be associated with a clinical improvement with reduction in incidence of OIs.

Conclusion

Very few patients can afford HAART for prolonged time.

2NRTIs a relatively cheaper combination, is useful in controlling HIV related recurrent infections. The combination provides good quality of life, patients can resume their jobs and start earning for themselves & their family. 2 NRTIs are well tolerated drugs. Long term prognosis may be unfavorable but immediate prognosis and first 48 week's prognosis is definitely better for those who can afford 2 NRTIs. Here the word of hope is that we have other combinations are open after patients start having decline in CD4/CD8 lymphocyte counts. We may try d4T+ddi, add PI, NNRTI or HU.

When we are not aiming at a cure with ART, maintaining a good quality of life with survival benefits with 2 NRTIs is a reasonable choice.

CHEMOPROPHYLAXIS OF OPPORTUNISTIC INFECTIONS

Alaka Deshpande

HIV disease is characterized by progressive immunodeficiency increasing the susceptibility of the individual to various infections. In developing countries the HIV infected cases are vulnerable to several air, water and vector borne diseases. In addition, the immunodeficiency reactivates may latent/dormat infections. These

opportunistic infections are responsible for profound morbidity and mortality of HIV disease. The advent of HAART therapy has altered the epidemiology of OIs.

The nonavailability and nonaffordability of ARV drugs, in resource limited countries, the patient need to be protected by chemoprophy laxis against OIs.

The goals of chemophrophylaxis are -

1. to prolong the survival time.
2. to reduce the morbidity
3. to improve the quality of life.

The commonest life threatening OIs in India are Cryptococcal meningitis, Toxoplasmosis, Cryptosporidia & Isospora, CMV, PCP and PML.

Before initiation of chemophrophylaxis it is necessary to educate the patient regarding personal hygine, drinking water, food habits etc. Wherever possible he should take precautions to prevent the exposure to OIs. Ideally the chemoprophylaxis should be initiated when CD4 cell count decreases to less than 200 cells/Ml. In case of the nonavailability of CD4 facility, clinical parameters should help the clinicians. If a patient presents with any of the AIDS defining diseases listed by CDC USA, he should be started on primary chemoprophylaxis. A patient who suffers from any OI, after specific therapy, must continue on secondary chemoprophylaxis, for that OIs for life time.

The drug therapy will be presented in detail.

MANAGEMENT OF OPPORTUNITIES INFECTION - WHAT HAVE WE LEARNT IN THE LAST TWO YEARS?

Abraham OC

Human Immunodeficiency Virus (HIV) infection is characterised by very high rates of viral replication and progressive decline in the number of the helper subset of T (CD4) lymphocytes. This, in turn, leads to the development of opportunistic infections (OI), the hallmark of severe immunodeficiency. The common OI seen in HIV infected individuals from India are tuberculosis, candidiasis, cryptococcosis, Pneumocystis carinii pneumonia (PCP), toxoplasmosis and chronic diarrhoea due to a variety of protozoal organisms. In developing countries, widespread use of OI prophylaxis and introduction of highly active antiretroviral therapy (HAART) has lead to a dramatic decline in the incidence of OI, even in patients with advanced HIV disease. The success of HAART has lead to new guidelines for OI prophylaxis, which recommend discontinuation of prophylaxis against specific OI when the CD4 count increases in response to HAART. This presentation will review the recently published literature on the management of OI, both prophylaxis and treatment.

DOTS-PLUS-IMPLEMENTATION IN THE ERA OF HIV AND AIDS

Manjula Datta, Kalpana S, Neelofer S

That tuberculosis is by far the commonest opportunistic infection in AIDS, is well accepted. It is also accepted that TB co-exists with, is worsened by, and worsens by HIV infection. The emergence of drug resistance has underlined the need to urgently cut down the transmission of TB. The strategy' of DOTS works very well in the general populations. Whether it performs equally well in those with HIV,Remains to be seen. Meanwhile, improvements of the regimens and drug delivery have been suggested. These need careful attention. The performance of DOTS and DOTS-plus and their potential for TB control in the face of an advancing HIV epidemic will be discussed.

TREND OF HIV INFECTION IN PATIENTS WITH TUBERCULOSIS IN RURAL INDIA

Rajasekaran S, Uma A, Jeyaganesh D, Senthamizhchelvan A, Savithri S,

Background

HIV and tuberculosis coinfection is on the rise in certain urban pockets of India. In a first ever study, the trend of HIV infection among tuberculosis patients was assessed at Thanjavur, predominantly a rural place in south Inida.

Methodology

HIV seropositivity was assessed during 1996 among 510 confirmed tuberculosis patients attending Govt. Raja Mirasudar Hospital, Thanjavur. The findings of this sentinel surveillance was compared to the 1999 survey conducted among 405 confirmed tuberculosis patients. Agriculturists & farm labourers constituted 65 / of study population.

Results

HIV seropositivity was 0.59% among 510 tuberculosis patients in 1996 and the rate was found to increase alarmingly to an extent of 8.9% among 405 tuberculosis patients surveyed in 1999. Disseminated tuberculosis and atypical radiological patterns were also observed in 1999 survey.

Conclusions

HIV infection is making strong inroads in the agriculture belts of south India, hitherto considered as low prevalence zones. The study also revealed that a sizable proportion of patients with HIV and tuberculosis confection is in the late phase of immunosuppression.

TREND OF HIV INFECTION IN PATIENTS WITH TUBERCULOSIS IN RURAL INDIA

Rajasekaran S, Uma A, Jeyaganesh D, Senthamizhchelvan A, Savithri S,

Background

HIV and tuberculosis coinfection is on the rise in certain urban pockets of India. In a first ever study, the trend of HIV infection among tuberculosis patients was assessed at Thanjavur, predominantly a rural place in south Inida.

Methodology

HIV seropositivity was assessed during 1996 among 510 confirmed tuberculosis patients attending Govt. Raja Mirasudar Hospital, Thanjavur. The findings of this sentinel surveillance was compared to the 1999 survey conducted among 405 confirmed tuberculosis patients. Agriculturists & farm labourers constituted 65 / of study population.

Results

HIV seropositivity was 0.59% among 510 tuberculosis patients in 1996 and the rate was found to increase alarmingly to an extent of 8.9% among 405 tuberculosis patients surveyed in 1999. Disseminated tuberculosis and atypical radiological patterns were also observed in 1999 survey.

Conclusions

HIV infection is making strong inroads in the agriculture belts of south India, hitherto considered as low prevalence zones. The study also revealed that a sizable proportion of patients with HIV and tuberculosis confection is in the late phase of immunosuppression.

MDR-TUBERCULOSIS IN HIV INFECTION-INDIAN SCENARIO & MANAGEMENT

Jaising Phadtare

Drug resistant tuberculosis in general and MDR-Tuberculosis inparticular has posed an alarming concern in India due to failure of effective implementation of National tuberculosis Control Programme. Prevalence of MDR-Tuberculosis in HIV afflicted group is in no way different to that observed in the general population. Principles of management, treatment regime & its duration remains the same in both the groups. Mortality is higher in MOTT afflicted individuals. The success rate is extremely lower than desired in both the groups. There appears to be drug interaction between anti-TB and anti-retroviral drugs. Expensive treatment, lack of proper drug supply, untoward effects and paucity of good thoracic surgery centres remain the major obstacles in the management.

High degree of clinical suspicion supported by conventional culture and susceptibility study is essential for establishing the diagnosis. However, lack of good referral labs, standardisation of techniques, quality control and paucity of expertise remains the stumbling blocks. Allocation of atleast 10% of the total budget (earmarked for management of tuberculosis) for development of referral labs, teaching, training and service centres which are fully equipped and properly staffed along with optimum drug supply and delivery system is desired. In India, multi-centric epidemiological studies based on a common protocol for detection and management of MDR-Tuberculosis is necessary.

But inspite of all the high-tech gadgets and treatment modalities, even today the best way to treat MDR-TB is to prevent it. This can be achieved by implementing judicious category based treatment plan i.e. directly observed or supervised.

"MANAGEMENT OF OPPORTUNISTIC INFECTIONS"

Sankaran JR

Opportunistic infections (OIs) are the prime clinical presentations of HIV illness and profoundly influence patients quality of life and survival. It is now known that the prevention of OI s in patients with HIV prolongs life. The introduction of new antiretroviral drugs to control HIV and effective chemotherapeutic agents to prevent HIV associated OIs have significantly improved the clinical management of HIV. The emphasis is now shifting from treatment of OIs to their prevention. Clinicians need to be aware of the rapidly changing diagnostic, preventive and therapeutic guideliness for managing HIV-associated OIs as well as of the potentially harmful side effects and drug interactions inherent in the therapeutic regimes for successful clinical management of OIs in HIV disease.

OPPORTUNISTIC INFECTIONS IN AIDS DISEASE IN INDIA

Jayakar Paul

The Data presented is based on my clinical experience as Professor in-charge of AIDS patients in the Govt. General Hospital . Madras in the Management of more than 150 AIDS patients admitted in the 26 bedded AIDS ward from the year 1987 to 1994. Ethnic , Cultural and Environmental factors in every country alter the clinical presentation of AIDS to a certain degree. The Clinical profile of AIDS in India is presented now. Both HIV I and HIV II viruses infect the Indian population [HIV I -80 % : HIV II-6 % : HIV I & HIV II-14 %]. The Clinical Diagnosis of AIDS is based on WHO criteria and confirmed by Elisa and Western Blot tests. It is worth knowing the various OPPORTUNISTIC INFECTIONS occuring in AIDS patients in the Indian setting for proper management of AIDS disease. In the first 56 cases studied from years 1987 to 1992, the incidence of the Opportunistic infections were : -Tuberculosis -56 %. Cryptosporidiosis -32 % Candidiasis -28 %, Dermatophytoses -16 %, Amoebiasis -12 %, Giardiasis -8 %, Herpes -6 %, Helminthiasis -6 %. Furunculosis 6 %.

Warts -4 % & CMV Retinitis -2 %. In the next 100 cases studied, the incidence were slightly different : -Tuberculosis -51 %. Candidiasis -41 %. Cryptosporidium - 16%. Dermatophytoses -16 %, Intestinal Parasitosis -8 %, Herpes 5 %, Furunculosis -5 % and Scabies -4 %. As the AIDS epidemic evolves, more and more Opportunistic Infections become common. The etiology of these Opportunistic Infection were found to be : -Bacterial -62 %. Parasitic -58 %. Fungal -44 % and Viral -18 % of cases. Various Studies were mounted in these AIDS cases to find out the Organ system involvement. The Systemic involvement were found to be : -Gastro-Intestinal - 58 %. Respiratory -58 %. Skin -28 %. Central Nervous System -14 %. Genito-Urinary -8 %, Hepato-Biliary-6 %. Musculo-Skeletal -2%. Endocrine -2 % and Eye -2%. It is important to note that all the organ systems of the human body are involved in AIDS disease -a really multisystemic disease. More than one infection and more than one organ are involved at the same time. The most important and the commonest Opportunistic Infection is Tuberculosis -both Pulmonary and Extra-Pulmonary. It is a health hazard to the Health care-givers and the care-takers of the AIDS patients in their house. The incidence of Tuberculosis was found to be : -Pulmonary -80 % and Extra-Pulmonary -20 %. The Gastro-Intestinal System and the Respiratory System were affected equally with an incidence of 58 % each. Skin involvement by various common and Opportunistic pathogens comes next in frequency with an incidence of 28 %. The Central Nervous System comes next in order with a frequency of 14 % of cases. AIDS being a news disease, several in-depth studies were conducted to find out the various individual systemic involvement and their manifestations . An In-depth study of 40 patients of AIDS with Gastro-intestinal manifestations presented with the incidence of:-Dysphagia-90% of which 85% due to Oro-Oesophageal Candidiasis Diarrhoea -80 % of which 40 % due to Cryptosporidial infection. Abdominal Colic -85 % and Gastro-Intestinal Bleed -7.5 % due to CytomegaloVirus, common Bacterial and HIV Entero-Colitis. An in-depth study of 20 patients of AIDS with neurological manifestations revealed :-HIV Encephalopathy -AIDS Dementia Complex - in 80 % of cases. HIV Radiculopathy-5%. Herpes Zoster-Multidermatomal-35 %, TB Meningitis -15 %. Cerebral Toxoplasmosis -10 %. Cryptococcal Meningitis-5 % and Multiple CNS presentations-35%. These figures enlighten the actual incidence of the various Opportunistic Infections associated with AIDS in the Indian scenario.

TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY
CHENNAI
HEALTH FOR ALL

CAN THE 184V MUTATION HAVE CLINICAL BENEFIT?

Mark A. Wainberg
Professor at Mc Gill University, Montreal.

The 184V mutation in the reverse transcriptase (RT) gene of HIV-1 is associated with high-level (i.e. 1000-fold) resistance against 3TC as well as low-level resistance (i.e.,5-10 fold) against each of Videx, ddC, and Abacavir. In addition, this mutation confers to HIV each of the following:

1. a marginally diminished ability to grow in certain cell types, i.e. "reduced fitness"

2. a modest increase in the "fidelity" of the viral RT, such that this enzyme may make fewer errors or be less error-prone than the RTs of wild-type or drug-sensitive viruses;

3. a modest decrease in the "processivity" or efficiency with which the viral RT copies viral RNA to produce the DNA that becomes integrated into host cells.

While other mutations in the viral RT may also have impact on "fitness", none apparently does so to as great an extent as does the 184V substitution. This helps to explain why patients who are taken off 3TC treatment may quickly lose the presence of detectable 184V-containing viruses and why this happens to a lesser extent with mutations associated with resistance to other drugs, e.g.ZDV. In addition, the fact that three distinct and possibly independent effects are associated with the 184V substitution suggests that this mutation may possibly confer clinical benefit by rendering HIV less capable of undergoing rapid replication and, by inference, of mutating into new forms. The "184V fidelity hypothesis" articulates that such viruses might have a reduced capacity to become resistant to drugs that impose a "high genetic barriers", such as certain Protease inhibitors, or to escape immunological effect or mechanisms as quickly as do wild-type viruses.

A number of clinical studies now suggest that patients who harbor the 184V mutation may continue to benefit from treatment with 3TC, in spite of the fact that no possible anti-viral pressure such that the 184V mutation remains in place. In this context, it could be argued that patients

who harbor this mutation might benefit from a switch in therapy from 3TC to either Videx or Abacavir, since both of these drugs might also serve to maintain pressure to keep the 184V substitution, while, at the same time, exerting an anti-viral effect. This concept can and should form the basis of clinical trials, in which patients who harbor the 184V mutation could be randomized to a number of alternate regimens that would or would not be expected to maintain this mutation in place.

"OCULAR LESIONS IN HIV POSITIVE/AIDS PATIENTS IN INDIA"

Jyotirmay Biswas MS

According to National AIDS control organisation (NACO), India is currently having 3.5 million HIV infected individuals. Ocular involvement is seen up to 70%. However, only few reports of ocular lesions in AIDS in India is available. Since our first report two cases of ocular lesions with AIDS in 1995, we have seen till date 220 cases of HIV infected patients. A series of 100 cases of ocular lesions in HIV has been published by us The majority of our patients were male (75%), of 20-40 years age group. Most common ocular lesions were cytomegalovirus retinitis (17%), followed by HIV retinopathy (12%). Other lesions include molluscum contagicsum, lid ulcer, herpes zoaster ophthalmicus, optic atrophy, acute retinal necrosis, progressive outer retinal necrosis, anterior uveitis, optic atrophy. Ocular lesions were less compared to us studies but more than seen in African patients. Correlation with CD4 + cell counts could be done in limited cases due to financial constraints. Lower CD4 cell counts correlated well with ocular lesions particularly CMV retinitis.

MANAGEMENT OF OPPORTUNISTIC INFECTIONS IN HIV DISEASE IN PUNE

Pujari Sanjay

In developing countries like India, management of HIV infection heavily relies on aggressive treatment and prevention of opportunstic infections (OI's). Systematic studies have demonstrated the positive impact of management of OI's on quantity and quality of life of HIV infected individuals. With Highly Active Antiretroviral therapy (HAART) being largely unaffordable, it is important for physicians to know the common OI's and their management in India. This presentation will cover some of the very practical points involved in management of OI's. Many of these interventions are extremely cheap and can significantly improve morbidity and mortality amongst HIV infected individuals with OI's. Management of tuberculosis, the commonest OI in India has some unresolved issues that need to be addressed -number of drugs and the duration of treatment. Of course prophylaxis is extremely controversial and in the absence of substantial data and fear of development of resistantce. we do not offer prophylaxis to HIV infected individuals. In patients with FUO an USG abdomen is absolutely essential and if shows abdominal nodes empirical ATT may be instituted. Most patients with FUO will have dramatic response to this treatment, chronic diarrhea is usually caused by protozoa viz. I.belli, cryptosporidia and cyclospora. A simple modified ZN preparation of stool helps in diagnosis. Empirical therapy with TMP-SMX may be tried in patients whose stool does not show these organisms or when this test is not done. Azithromycin may be tried in patients with cryptosporidiosis. A careful watch on fluid and electrolyte status is absolutely essential while managing these diarrheas.

CSF letting (30 cc/alternate day) can significantly alleviate headache amongst patients with cryptococcal meningitis being treated with anti-fungals. A careful watch on Serum potassium is essential when patient is taking Amphotericin B. Liberal fluid intake is recommended for patients on Amphotericin B to prevent development of renal toxicity. Any focal neurological deficit or seizures with a ring enhancing lesion on CT scan should be an indication to put the patient on empirical anti-toxoplasma treatment. When managing toxoplasmosis with pyrimethamine / sulphadiazine always use

folinic acid to prevent development of pyrimethamine induced bone marrow toxicity. Any patient with breathlessness, dry cough and unremarkable chest Xray should be evaluated for PCP. In management of PCP, steroids are useful when patients' ABG demonstrates a paO<70. Severe TMP-SMX hypersensitivity can be managed by desensitizing. Keeping a high index of suspicion in practice will help in early diagnosis of OI's amongst HIV infected individuals. Fortunately many OIs can be treated effectively. Important elements of good OI management includes a good clinical examination, judicious use of lab investigations and a thorough knowledge of medical management.

MANAGEMENT OF HIV/AIDS IN A TEACHING HOSPITAL IN MUMBAI (BOMBAY)

Janak Maniar

The management of HIV/AIDS in teaching hospital is a state of art knowing HIV medicine is 3 distinct specialty internationally recognised. The HIV/AIDS epidemic has matured in Metropolis of Mumbai which is referral centre for medical treatment. AIDS clinic in teaching hospital having experience of managing over 34,500 HIV +ve individual have following objectives; a) studying natural History of HIV infection in India, Observing spectrum of opportunistic infections, cost effective therapy comparing cost of treating opportunistic infeciiona v/s conservative use of antiretroviral therapy. c) cost effective perinatal HIV intervention? d)study psychosocial aspects of HIV/AIDS, e) undertake collaborative researches on epidermology of HIV infection viz studying variations in HIV 1, HIV 2, and dual infections. HIV seroepidiemiology etc., f) strengthening universal precautions, g) co-ordinating multidisciplinary health care providers for better management.

Presenting features have high positive predictive value for HIV/AIDS; viz fever of unknown origin, tuberculosis, recurrent or chronic diarrhea, chronic cough , unexplained weight loss, oral/esophageal candidiasis, unexplained lymphadenopathy, tuberculosis, herpes zoster, bell's palsy, extragenital molluscum contagious, PCP, cryptoccocal meningitis, TB meningitis,

toxoplasmosis cerebral, oral hairy leukoplakia, addisionion pigmentation, reactivated herpes simplex, idiopathic thrombocytopenic purpura, anemia etc

Early recognisation HIV related presenting features and opportunistic infection followed by prompt treatment shall prove beneficial to in restricting immune system damage. It is not unusual to see more than one OIs at a given time in atleast 60% of symptomatic individuals. Intensive counseling not only of the patient but important family members is mandatory. The psychosocial support and nutritional advise is also essential.

Only small number of HIV +ve individuals can financially afford antiretroviral therapy, pre and post treatment counseling for individuals receiving ART have ensured compliance. Perinatal HIV interventions should be the priority. The day care unit facilities have reduced inpatients work load. Similarly home base care for terminally sick patients is being encouraged.

PROMOTION OF RESPONSIBLE REPRODUCTIVE HEALTH BEHAVIOUR AMONG THE YOUTH

Laskhmibai

Background

Approximately one third of the worlds population is between 10- 24 years of age and their reproductive health needs and health rights are inadequately addressed. Sexually transmitted infection (STIs) including HIV are most common among young people aged 15-24. The adolescent is challenged with reconciling social and familial norms of behaviour with emerging sexual feelings and desires.

Need for the hour

Adolescent ignorance about the sexual and reproductive behaviour is compounded by a reluctance among parents and teacher to impart relevant information. Mothers expect their adolescent children particularly daughters to remain uninformed about sex and reproduction. Sex and puberty were considered to be embarrassing, distasteful and dirty subjects not to be discussed with their adolescent children. The

education system is also ambivalent about imparting sex education. Teachers by and large find the topic embarrassing and avoid it and as a result of the general reticence of both parents and teachers to address these issues, the main source of knowledge for those who are aware of sex and reproduction and of STDs / HIV / AIDS remains the mass media. Therefore education becomes important in imparting knowledge on reproductive health, STD/HIV/AIDS and condoms to the young people.

Intervention activities

In recognition of the enhanced risks faced by young people AIDS Prevention and Control (APAC) has funded a peer educator model program for HIV / AIDS Tamil Nadu, which has offered an appropriate setting for HIV related education. This state wide program was implemented by the department of Adult and continuing education, University of Madras over a period of 2 years in 20 selected colleges affiliated to the University of Madras. The program consisted of factual information and education to the young people. Peers among the college students will be the right disseminators of such information. Therefore the main component of the program was the peer promotion. An AIDS kit comprising of instruction materials on HIV/AIDS was given to peer educators in the training program. These trained peer educators were utilised as core change agents to implement the program by influencing knowledge on HIV/AIDS and condom usage among students through peer interaction.

Summary of Performance

HIV/AIDS is a sensitive and intimate issue and the Peer Educator Model utilising the Peer Educators as change agents has been found effective Include HIV/AIDS education as part of the curriculum as voiced by the academicians. Provide updated IEC materials specific to the target group.

FROM THE CRADLE TO THE BED

Anjali Gopalan

The unmapped territories of youth and sexuality. Sexuality is not just sex. It includes sexual identity, knowledge of ones own body, where and how you fit into the sexual world, relationships with others. A large proportion of the population would say that there is no point in linking the terms "youth and sexuality" as the terms are diametrically opposed. This head in the sand attitude, leads inability to communicate with or relate to the opposite same sex, sexual abuse remains rampant, yet hidden; and there is an increased vulnerability to STDs and HIV.

The best step forward is mandatory sex and sexuality education for young people. School is the most obvious place to access young people, however as there are a large number of young people who do not attend this institution, other avenues need to be explored.

VICTIM OR VIRGIN

Amanda Murphy

Issue is the definition of the role of women in successful intervention work. Since 1995 The Teddy Trust has integrated the business activities of Teddy exports with AIDS awareness in Tamil Nadu. This includes working with commercial sex workers in the 13-50 age group, women in the work place and young people. Ultimately the responsibility of fighting the AIDS epidemic falls to the wife/partner/mother. Women always seem to take the blame. Efforts to raise awareness about AIDS have only succeeded when combines with constructive role models which elevate the female status. This has been achieved through real life experience, role play and the strengthening of the sisterhood which already exists. Access to quality health care and empowerment offering equal employment rights are vital as well as a realistic attitude towards the needs of young people of Madurai to-day. Myths and stigma must be removed, and parents involved.

Lessons learnt

The Teddy Trust sees women as the strongest army against HIV/AIDS. The realisation that women are responsible for their own future is the key to success "You can lead a horse to water but you cannot make it drink".

CARING FOR THE COMMUNITY IN TIME OF AIDS

Joretta L.Marshall

Pastoral caregivers representing various religious organizations can offer support and assistance to individuals, families and communities as we all struggle with the reality of AIDS. As representatives of faith traditions we can offer perspectives on ministries of healing, reconciling, guiding and sustaining.

This paper will look at these four activities of pastoral care and offer suggestions on how to minister not only to the needs of individuals living with AIDS, but to families and communities of faith as well. In addition, the paper will address some of the ways in which representatives of various religious traditions can offer a prophetic vision to the culture as it addressess issues of spirituality and sexuality.

RELIGIOUS HINDU APPROACH TO HIV/AIDS: EDUCATION AND PREVENTION

Swami Sri Jnanaswarupananda

It is high time that science and religion joined together to bring solace to the human sufferings. Hindu religion is not against reasoning. Rather it directs humanity to higher knowledge by which one attains eternal joy and peace.

The Hindu life is divided into four stages viz. Brahmacharya, Garhasthya, Vanaprastha and Sannyasa. By leading such a life, a true Hindu may escape from vulnerable diseases like AIDS.

Chastity is the highest virtue for men and women. A good chaste wife considers every other man except her husband as her father / brother / Son. Similarly every husband looks upon all women other than his wife as mother or daughter. Sri Ramakrishna, the saint of modern India says that after begetting one or two children, husband and wife should live like brother and sister. His own life itself is a shining example.

Part of human energy which is expressed as sex energy when checked and controlled becomes changed into the highest energy (Ojas) by using which one becomes aware of one's own higher Self. Although the nature

of mind is outgoing through the senses it has to be trained by japa, prayer and meditation.

Hinduism shows four paths viz. Karma, bhakti, jnana, and raja yogas to rise to higher levels of Existence, Bliss, and Knowledge. Our younger generation should be shown the higher type of bliss available within oneself by setting higher goals of life. Within the curriculum there should be scope to get exposure to social and cultural values. Among the four yogas Raja yoga advocates a scientific approach to know and realize the higher Self by sublimating the unharnessed energies.

IN THE NAME OF ALLAH, MOST GRACIOUS, MOST MERCIFUL

Abdul Rahim A

Islam forbids and prohibits indecency, lewdness, nudity and adultery. The Holy Quran at one place chastises men involved in immoral sex in the following words: S.7 Sec. 10.80 to 84.

We also sent Lut : He said to his people. "Do you commit lewdnes such as no people in creation (ever) committed before you? For ye practice your lusts on men in preference to women: ye are indeed a people transgressing beyond bounds. Sura 17. A. 32 "Nor come nigh to adultery: For it is an indecent (deed): And an evil way: Adultery is not only shameful in itself and inconsistent with any self-respect for others, but it opens the road to many evils. It destroys the basis of the family: it works against the interest of children born or to be born: it may cause murders, feuds and loss of reputation and property, and also loosen, permanently the bonds of society. Not only it should avoid be avoided as a sin, but any approach or temptation to it should beavoided.

True, sex is a biological need of all animals including human beings. If I am not mistaken or can I say the religious teachings are properly understood sex of either gender is intented only for procreation and not for pleasure. Indiscriminate, promiscuous sex, whether it be homosexuality or hetrosexuality leads only to misery. Islam lays down that the man and the woman on their attaining the age or sexual urge should get married clearly indicating that

CHRISTIAN APPROACH TO HIV/AIDS EDUCATION AND PREVENTION

Rev. Mathew NG

The paper enumerates the Christian approach to the HIVIAIDS scenario. The emphasis is on the role of individuals and the community in handling the impending crisis by prevention and education, employing Biblical foundations. The Covenent Principle, Methodology of Christ, Conciliation and Imperatives for the Communities of Faith are the approaches discussed and suggested for integrated management of the Challenge of HIV/AIDS.

HIV/AIDS:LOVE, FORGIVENESS AND HEALING

Donald E, Messer

Most major world religions affirm the values of love, forgiveness, and healing. Mobilizing the manifestation of these values in the lives of individuals, faith communities, and the society could contribute to understanding and addressing the HIV/AIDS crisis in India. Religious leaders and communities can help the culture and society to move beyond denial and discrimination to ethical responses that recognize human realities, protect human rights, promote prevention by education, and ensure supportive care and relationships for persons with HIV/AIDS.

Donald E. Messer has served the past 19 years as President and Henry White Warren Professor of Practical Theology at the Iliff School of Theology, Denver, Colorado, USA. He is the author of nine books, including Caught in the Crossfire: Helping Christians Debate Homosexuality. He holds a Ph.D.from Boston University and studied at Madras Christian College, Tambaram, India from 1961-62. He has previously lectured at AIDS Conferences in the United States, Uruguay, and India.

IMMUNOPATHOGENESIS OF HIV DISEASE INCLUDING FACTORS INFLUENCING HIV INFECTION

Savita Pahwa,

HIV infection and disease progression are influenced by the interaction of viral factors and host factors. Host genetic factors viz. MHC genotype and chemokine/chemokine receptor polymorphisms and other, as yet, unrecognized factors confer resistance to infection and influence the intensity of immune response/disease progression in infected individuals.

Among HIV infected pregnant women, maternal plasma HIV RNA is the major risk factor for mother to child HIV transmission and vertical transmission increased with increasing HIV RNA levels. With respect to mode of delivery and gestational age, elective Caesarian section prior to onset of labor has been shown to substantially reduce the risk of transmission. Pre-term delivers, decrease antenatal maternal CD4 counts and chorioamnionitis at delivery are associated with greater risk of transmission. Studies of maternal virus indicate that perinatal transmission occurs with M-tropic viruses that utilize CCR5 as the chemokine co-receptor for virus entry into target cells.

In infected individuals, there is evidence for aberrant immune activation in association with profound qualitative and quantitative deficiency of CD4 T cells. The T cell deficiency is attributed to excessive T cell death and decreased T cell regeneration. Lymphocytes of patients exhibit activation markers (DR, CD38), Cytokine dysregulation, increased apoptosis, impaired lymphoproliferative responses to recall antigens, depressed HIV-specific immunity and a disrupted T cell receptor (TCR) Vβ repertoire.

Potent combination -antiretroviral therapy (ART), in infected individuals can lead to suppression of plasma RNA copies to low levels, increase CD4 cell counts, normalize immune activation, immune activation markers, decrease lymphocyte apoptosis and improve immune competence, thereby minimising the risk of opportunistic infections, reducing hospitalizations and increasing survival. Despite the marked reduction in HIV RNA levels in plasma, the virus is not eradicted and latently infected cells persist; if therapy is discontinued; the virus rebounds.

Recent technological advances have made it possible to investigate HIV-specific immune responses, e.g. by assays for quantitating HIV -specific T cells by tetramer binding and effector function by pCTL/Elispot assays. Furthermore, recent thymic emigrant cells can be quantified by PCR for TCR rearrangement circles (TRECs). With effective ART there is evidence of thymic regeneration but deficiency in HIV-specific CD8 T cells may persist.

The goals of therapy for HIV -infected individuals in the developed world are to minimize the virus burden, preserve immune function and boost HIV specific immunity. Current knowledge of interventions during pregnancy/delivery/post-partum period can be applied in the developing world to dramatically reduce to incidence of new perinatally acquired infections. Prvention and treatment of co-infections and opportunistic infections can potentially delay disease progression in infected individuals who do not have access to potent ART.

HIV / RESISTANCE, DRUG HOLIDAYS AND SALVAGE REGIMEN REAL WORLD EXPERIENCE FROM A LARGE PATIENT COHORT

Hans Jager M.D

Drug Resistence testing ,even though expensive, has started to become a regular feature in clinical AIDS work. In addition to CD4-positive lymphocytes {helper cells }and HIV- virus load resistance emerges as a third parameter with growing importance. Clinical decision making based on resistance is more effective regarding improvements in immune system and virus load and with that potentially in clinical out-come.

For practical purposes we have chosen genotypic resistance as opposed to phenotypic resistance to be performed in our own group. Short turn- around-times ,practicability, somewhat higher clinical relevance and low cost being the main reasons. Phenotypic resistance in clinical experience especially patients with advanced disease showed somewhat predictable results with high {>10 times resistance for most drugs ,the trio d4t ddI and adefovir being the exceptions from the rule {resistance often in theorder of 4 -10times}.

Drugs Holidays

We have started a project studying structured drug holidays in 1999 based on

1. In recent years our practical experience has suggested that apart from toxicity levels, the short interruptions did not jeopardise the pre-existing therapeutic effectiveness.

2. Data from hydroxyurea containing regimens by Fronco Lori, who showed that the intervals between stopping drug and reemergence of virus become longer with repeated drug holidays.

3. Drug interruption studies at the NIH ,Washington and the Aaron Diamond AIDS Research Centre, New York City{results pending}

So far our data indicates that

1. Drug holidays are a feasible concept with no direct threat of progression in patients whose virus load is well controlled.

2. Three specific patterns of viral rebound that will be discussed.

3. Robust CD4 counts that in many cases do not change much during drug interruption.

4. Clinical benefit (less toxicity, especially less fatigue , considerable Clinical decrease of cholesterol and triglycerides no clear improvement of fat redistribution cholestero).

5. Psycological benefit.

REALISTIC APPROACH TO THE CONTROL OF STD'S IN INDIA

Ramasubramanian, V

STDs represent major health, social and economic problems in a developing country like India with significant mortality, long term morbidity and stigma. Measures are needed to construct a paradigm based on broad approaches incorporating social, cultural, economic and political dimensions along with medical interventions. These should not only target the prevention of new infections and the treatment of symptomatic patients by means of syndromic management, but also identify asymptomatic infected people and motivate in them a health seeking behaviour. Health promotion strategies through targeted interventions that promote behaviour changes, along with the development of services streamlined for inexpensive and basic treatment of STDs at the PHC level must be encouraged. Adequate training of health care workers and a pragmatic approach with non-judgemental attitudes will help to stem the tide of rising STDs.

ON A GLOBAL BASIS HIV INFECTION

Catherine Peckham

On a global basis HIV infection is now one of the leading causes of death and the HIV epidemic among children is responsible for the slowing, and in some cases reversal, of the decline in infant and child mortality in the developing world. Vertical transmission of HIV infection from mother to child accounts for over 90% of HIV infection in children and as the prevalence of infection among women of child bearing age continues to rise increasing numbers of children are at risk of infection. It is estimated that 2.4 million HIV infected women deliver babies each year resulting in 600,000 new infections in infants annually. In some parts of sub Sahran Africa as many as 20-30% of pregnant women are infected with HIV.

Mother-to-child transmission of HIV infection can occur before or during birth, or after birth through breastfeeding. In the absence of breastfeeding around two thirds of infections are acquired around the

time of delivery and the estimated rate of transmission is about 15-20%. In resource poor countries where breastfeeding is the norm transmission rate are higher, 25-30%. Other factors associated with increased vertical transmission of HIV infection include advanced maternal disease, low CD4 count and increased maternal HIV-RNA levels. Most studies show an increased risk of infection with increasing maternal viral load although there does not appear to be a cut off below which transmission does not occur.

Events during labour and delivery have also been associated with increased transmission risk, such as exposure to maternal blood and genital secretions during labour and delivery and prolonged rupture of the membranes. The administration of zidovudine to HIV infected women during pregnancy and in labour and to the neonate for the first 6 weeks of life greatly reduces the risk of tansmission. Caesarean section delivery has also been shown to reduce transmission, even among women receiving AZT prophylaxis. In most developed countries where antenatal HIV testing is routine and interventions to reduce transmission are applied the risk of perinatal infection is less than 5% and paediatric HIV has dramatically declined. More recently, several trials have demonstrated that short courses of antiretroviral therapy are effective in reducing mother-to-child transmission, even in populations where breastfeeding continues. These interventions, which are now being implemented as pilot projects in several developing countries, will be discussed together with issues relating to transmission through breastfeeding.

ANTIRETROVIRAL THERAPY IN RESOURCE POOR SETTINGS

Joep MA Lange

Only five years ago, therapeutic prospects for HIV-infected individuals were bleak. Suboptimal application, ie. as monotherapy or dual therapy, of the few drugs available did not lead to sustained virological, immunological and clinical success. With the advent of potent new drugs, multi-drug combination therapy, and the ability to quantify HIV burden the outlook has changed dramatically, as signified by enormous reductions in HIV-related morbidity and mortality in the industrialized world, compared to the pre-HAART (highly active antiretroviral therapy) era.

The great majority of HIV-infected people, however, live in the developing world, where the uptake of effective antiretroviral therapy has been hindered by economic and logistic constraints. Apart from the obligatory quest for an effective preventive HIV vaccine, we cannot remain passive to the suffering of the masses of people already infected. From a macro-economic perspective it may also be better to treat than not to treat. We thus have to search for antiretroviral therapies that are effective, affordable and sustainable in developing world settings. With a combined effort of supranational organizations, governments, pharmaceutical industry and dedicated experts it must be possible to construct such regimens. In many instances this will require considerable infrastructure strengthening. A beginning of this process may be made through the conduct of clinical trials, where the developing world offers unique opportunities.

STRATEGIES TO ELIMINATE DEEP SEATED PREJUDICES AGAINS THOSE INFECTED AND AFFECTED WITH HIV/AIDS

Ashok Pillai

I am glad to be here and share my views on the issue, which we all are grappling with. I have been living with HIV for the past ten years and during this period I have faced many incidents where my rights were violated in different settings, whether it was workplace, health care institutions or by friends. I have a learned through a very hard way that we can handle this situation ourselves if we are prepared to do so and if there is a support system available. I was able to cope up with the discrimination largely because I had received support of may friends and family, who have been supporting me since the day I told them about my status. This assurance that I have people around me, who will support me no matter what the circumstances are has build confidence in me and helped me to work towards the betterment of people living with HIV. Therefore, I have always stood firmly, whenever I faced any problems due to my HIV status.

Today my presentation focuses on my experience on handling this issue.

First, I would like to draw your attention towards the causes that has led to such discriminatory practices against people living with HIV. There are many but I will point out discriminatory practices against people living with HIV.

Fear based messages

Thirteen years, we have been seeing messages, which do not give any specific information about HIV or AIDS but are loaded with fear, for example - AIDS no cure, AIDS is equal to death etc. The messages has been successful in creating a scare in people's mind about AIDS but has also resulted in belief that people living with HIV/AIDS are immoral so it is okay to discriminate them! The belief that people living with HIV are going to die soon has created a mindset that people suffering from AIDS, should be kept at bay and their company should be avoided. Now if somebody

wants to avoid getting HIV, they try to avoid touching, kissing or even talking to people living with HIV. This is because there is no information about how this disease does not spread through casual contacts.

I won't get it'

Because of constant messages about morality there is a belief that "immoral sex" causes AIDS. People who are living with HIV do not want to disclose their status to anyone because of the stigma attached to the disease. They know that they will not be accepted by the society so they choose to live in closet. This has resulted in invisibility of the epidemic in India, despite the large number of confirmed and estimated cases in the paper. People feel that their immediate surroundings are safe as they do not know that somebody whom they know might be living with HIV but is not disclosing the status. Therefore, for almost everyone it is a disease, which will not affect him or her. "I wont get it". THEREFORE, AIDS is a topic of laugh, jokes and fun for majority ofthe people rather than a serious threat to the community.

Targeted interventions vs. General Population

If you notice, you will realize that all the intervention program still focus on the so called "High risk groups" i.e. truck drivers, women in prostitution, S.T.D clinic attendees etc. But the groups, which are vulnerable to HIV are totally ignored for example- school & college youth, Men who have Sex with Men mobile population etc. Prevention messges are much generalized and do not reach anybody. No campaign talks about the rights of people living with HIV; so, people have a mindset that it does not, matter if they discriminate somebody who is living with HIV. In any case, they are going to die ! All this has caused confusion as to what the message should say and to whom.

No law/forum to address human rights violations

In absence of any law, which Prohibits the discrimination based on the health status of the person, people discriminating people living with HIV go scot-free. In addition, the prejudice against people living with HIV among judges and lawyers has resulted in people living with HIV losing all the cases they file in the courts. Hence, most of the violations go unnoticed

and unreported. This also encourages people to continue practicing such discriminatory practices.

Now having understood few of the factors that leads to discrimination of people living with HIV/AIDS, we have a question as to how to handle the situation. The strategy which might be useful in eliminating the discrimination can be ever evolving and based on my personal experience and observation, I would like to suggest few steps which can help improving the situation.

Information vs. Fiction

We need to provide information about HIV/AIDS, as to how it spreads and how it does not. In addition, the fact that people living with HIV do not die soon after they are tested positive is also unknown to many people! We have to inform people that people living with HIV live healthy and productive life provided they have good support system. The information about positive living and human rights should be given to people living with HIV, which will help people living with HIV to respond to the violations of their fundamental rights. Such messages will also help to remove the misconception among people's mind. At present, we see only fictional messages most of the time, which do not give any information For example, messages like "Kiss can lead to death" or "Can you spot a rotten egg in the basket " can only create confusion among general population

Integration of Human rights in prevention and care and support programs

In India all the programs on AIDS are preventive one and do not have any emphasis on human rights. For example there is a common practice among counselors to tell people living with HIV not to have sex or get married. Such incidences do not help in prevention of HIV but are violation of fundamental human rights. Even care and support program do not focus on patient's right to information. A person living with HIV does not receive any information on the treatment he is receiving or about the status of his/her health. This results in people living with HIV not realizing as what they are supposed to receive as a consumer of such services. The Perspective or personality of victim of the human right violation is also very important in planning the strategy or any intervention against such incidents.

Multi-Sectored response

In 1986 when we detected the first case in India, everybody thought that this is a health crisis and India would not be affected. Nevertheless, today we have 3-5 million people living with HIV and still many believe that HIV is a public health problem. We need people from various walks of life to work towards prevention and care. We need human rights NGOs, Organizations working in the area of development, ministries other than health etc. to make the response a Comprehensive one.

Anti Discriminatory Law

Today we do not have any law, which prohibits people from violating the rights of people living with HIV. From my own experience, I have realized that there are no rights unless the law enforces it. Therefore, I strongly believe that unless and until there will be an Anti-discriminatory law the incidence of violation of human rights will continue to happen and prevention won't work. How the human rights and prevention are interlinked is a big topic for debate and I do not wish to spend time on that but an example on the issue might help you to understand its importance. Suppose a person who is living with HIV faces discrimination, he/she chooses to remain silent about his status. The next time he/she goes for medical check-up or sex where there is a chance of transmitting HIV he / she remains silent fearing the discrimination. As long as there is no protection of human rights of people living with HIV, we will have invisible epidemic in India and that is a big barrier for prevention

I want to go on outlining the whole problem but may be this discussion can continue even after the conference.

To conclude my presentation I would like to draw your attention to few points that might help you to understand the problem from the perspective of people living with HIV.

- People living with HIV are very important in the prevention of HIV in India because if they are not part of the prevention then it will not be successful. Though our efforts should focus everybody in prevention, it should not be at the cost of people living with HIV. I mean that there

is no point talking about AIDS or condoms to 99% of population, which is not infected, with out talking to 1% population, which is infected and can pass on the infections to others if not given enough information about HIV/AIDS or positive living. Their rights are to be respected as itwill bring them into main stream of the AIDS program.

- We should know by now that AIDS affects us all and everybody has responsibility to stop this disease from destroying anybody anymore. In 1986 there were only few cases but we didn't bother, today we have 3-5 million and we still have the same attitude but for the few who have taken up the challenge tofight against the epidemic.,
- We should start thinking of integrating Human rights into the prevention and care programs, as it will help these programs to achieve great results. No human rights, no prevention. Remember.
- AIDS is closer than you think so do not wait for AIDS to hit your home. Do not think that I am not affected. I did the same mistake of waiting, and today I am infected and my family and friends are all affected by AIDS.

POVERTY, INEQUALITY AND AIDS

Prem Chandran John

The problem of the poor - The extent of the problem - The origin and nuturing of inequalities - Public health problems rooted in the socio-economic context - Health is Politics on a large scale (Virchow) - Illness pattern of the Poor over the last five decades. Responses of the government, of NGOs and others - Power equations in the country, the weakest are also the sickest - Decision making in and allocations to health sector and to rural health - Changing illness patterns, re-emergence of older diseases and emergence of a new generation of diseases - Unchanging public health responses - Changing paradigm of health policy formulation - AIDS as an integral part of the public health problem selctively affecting the South (85% vs. 15%) now and in the future - Developmental and economic consequences of diseases of poverty, specially AIDS - The role of the voluntary sector and the role of the community - Agenda for the new Millenium.

THE IMPACT OF HIV/AIDS ON ECONOMIC DEVELOPMENT

Puneet Mahajan

HIV / AIDS is a major public health problem throughout the world, particularly in the developing countries. By UNAIDS estimates, there were 33.4 million people living with HIV/AIDS in 1998, of whom 22.5 million were in sub-Saharan Africa and 6.7 million were in South/Southeast Asia. Of the 5.8 million new infections world wide in 1998, sub-Saharan Africa and South/Southeast Asia accounted for approximately 4 million and 1.2 million of these new infections, respectively. With such prevalence and incidence rates, it is apparent that HIV/AIDS can have a severe impact on the economics of these regions. Because HIV/AIDS generally strikes younger people in their prime working years, there are not only diret and indirect medical costs associated with caring for people with HIV/AIDS., but there are also major consequences in terms of the over all labor supply. HIV/AIDS not only has an impact on the individual's suffering, it can have devastating effects on the entire household if the individual is unable to work and needs care. At the macro level, this disease has implications for the economic growth of businesses and ultimately overall gross domestic product (GDP) of the country. As an example, it was estimated that the total annual cost of HIV/AIDS in India in 1995 was in the range of 6.8 and 59 billion rupees (about 1% of GDP of India in 1995). This presentation will discuss the current and future economic impact of HIV/AIDS on economic development.

FACING THE THIRD MILLENNIUM -LONG-TERM IMPACT OF HIV/AIDS

Lars O. Kallings

India has yet to experience the heavy impact of AIDS as the HIV epidemics started comparatively late in the country. The wide spread of HIV began only some ten years ago. The majority' of the estimated 4 million people living with HIV in India will fall ill and die during the first decade of the next century. The impact will continue to increase above that, as there are no indications that the HIV incidence will decrease within the near future. Unless radical and efficient preventive measures are instituted now. the long-term impact of HIV/AIDS in India will be grave.

The increased morbidity 2nd mortality of people in their most productive ages will have serious economic consequences on the family, community' and national level. There will be a drop in life expectancy and a loss of skilled workforce across all society-levels. The worst case scenario will entail a degraded macro-economy and a deteriorating infrastructure.

Even the 4 million people currently living with HIV in India will result in an extra burden on the already over-stretched health care system. The need for treatment will be demanding, In comparison, Brazil is spending USS 300 million in 1999 to treat 75,000 HIV AIDS patients. It is important to realise that prevention and care go hand in hand. Prevention without care does not work. Treatment will also cut hospitalisation costs.

In 1999 about 60,000 new-boms were HIV infected in South and Southeast Asia. Today, women constitute about 30% of all people living with HIV in the region. Increased heterosexual transmission will result in a higher proportion of HIV-infected women and increased mother-to-child transmission (MTCT). Prevention of 50% of MTCT is possible today with relatively inexpensive and simple treatment but requires extensive counselling and HIV-testing. This in turn implies comprehensive societal interventions against discrimination and deep-rooted prejudices. The number of children orphaned by AIDS will also increase sharply. Already, some 200,000 children are estimated to have been orphaned by AIDS in South and Southeast Asia.

The magnitude of the HIV epidemics India will depend on the size of the population at risk The prevalence of other sexually transmitted infections indicates that major heterosexual population groups are at risk and are therefore vulnerable to wide spread of HIV. Only a profound national mobilisation to change attitudes and risky behaviour can prevent extensive epidemics and save India from the worst impact of HIV/AIDS in the next millennium.

"RECENT DEVELOPMENTS IN DIAGNOSIS OF SEXUALLY TRANSMITTED DISEASES"

Milton Tam

The number and variety of commercially available STD diagnostic tests is increasing.

Appropriate and cost effective diagnostic tests are urgently needed for control of STDs, since commonly used syndromic protocols can be less than accurate and may result in over-or under treatment of patients. Simple and rapid strip tests have been developed for syphilis and chlamydia that give same day results and can be used in health care clinics, such as antenatal and family planning clinics, that do not have onsite laboratory facilities. Additional simple and rapid tests for gonorrhea and other STDs have been developed, but have yet to be adequately evaluated in the field. In addition, several test kits using DNA probes and/or DNA amplification techniques have been recently introduced. These tests are capable of simultaneously diagnosing both chlamydial and gonorrheal infections; are very sensitive and specific; and can use relatively noninvasive specimens, such as urine. Since they are often more sensitive than culture, they are setting new standards for detection. However, since these tests are still expensive, highly complex, and equipment dependent, they can be only successfully applied at the central reference level. The strengths and weaknesses of representative simple/rapid and reference-level molecular diagnostic tests will be discussed and reviewed, and projections for future developments will be made.

COMMUNITY HEALTH CELL
LIBRARY
AND
DOCUMENTATION
UNIT

DIS.325
N99
0613

NEED TO INTEGRATE HIV AND STD DIAGNOSTICS FOR USE IN INDIA

Hira Subhash K

Rationale

HIV and conventional STD are linked biologically, behaviourally and socially.

Background

WHO estimates that India has occurrence of 20-40 million new cases of STD each year. High rates of syphilis (1-4%) and HBs Ag (2.5%) have been documented among antenatal attenders. A study conducted in Tamil Nadu showed that communitly prevalence of STD was 10% among asymptomatic adults in 1997. A study in Mumbai showed that 9% of STD clinic attenders were positive for HBsAg. Sentinel surveillance of HIV among STD clinic attenders across the country shows HIV prevalence between 5 and 45%.

Control Strategies

High rates of STD call for urgent control measures for STD in its own right. Although field-studies have shown that syndromic management of clinical STD is cost-effective, there is need for case finding for asymptomatic infections among priority groups such as blood donors, pregnant women, and STD clinic attenders. There is need to integrate testing with counselling for HIV and that for syphilis, Hepatitis-B &C, gonorrhoea and chlamydia among priority groups. Cost-effective approach will be to integrate diagnosis for HIV and selected STD on simple, rapid, and affordable diagnostics.

THE UTILITY AND COMPLEXITY OF HIV-1 VIRAL LOAD QUANTIFICATION

Best SJ

HIV nuclei acid may be detected either as RNA in plasma or as DNA in mononuclear cells. The principal use of plasma HIV RNA quantifiation is to monitor the efficacy of antiretroviral drug treatment in HIV infected individuals who have access to such therapy. In addition, if measured following seroconversion during subsequent primary HIV-1 infection, it can be a prognostic indicator of progression of disease.

Several commercial assays are available for quantifying plasma HIV RNA load. Included within each assay's protocol is a step in which an amplification of either target or signal occurs, though the principles and technologies of the assays differ from each other. Unlike the original versions of the assays, the latest versions are reported to measure to 50-100 HIV RNA copies/ml and exhibit essentially equivalent abilities to detect and quantify different subtypes.

But what does a viral load estimate mean? Data collected on Quality Control (QC) samples (also known as run controls)in the NRL's HIV Viral Load Quality Assuranc (QA) Program show that a viral load estimate can differ significantly.

- If measured in a different assay (inter-assay variability)
- If measured in the same assay but in a different laboratory (inter-laboratory (inter-laboratory variability)

Data are currently being collected from the latest versions of HIV RNA quantification assays which have been registered for use in Australia for 3-6 months.

The degree of inter-laboratory and inter-assay variability that we, through the NRLs QA program, and others observe dictates that monitoring of an individual's antiretroviral therapy must be performed in the same laboratory using the same assay. Furthermore, it is recommended that viral load levels within an individual patient that differ by less than 0.5 $\log_{10}$ copies/ml are considered not significant.

POTENTIAL BENEFITS OF POOLED SERA TECHNIQUE IN SCREENING OF HIV

Jacob Mini, Mary S, Parameswari S, Umayal, Ananda Kannan K, Samuel NM

Introduction

The most widely used test for identification of HIV Infection is the Enzyme Immunoassay (EIA) or ELISA. Pooled sera technique is an alternative to individual ELISA where a large number of samples need to be screened. The pooling procedure consist of groups of sera being assayed simultaneously per ELISA well instead of one sample per test well

Objective

The objective of this study is to assess whether testing of pooled sera Is technically feasible, cost effective and beneficial for estimating sero prevalence in large population surveys in India.

Material & Methods

One thousand two hundred and fifty blood samples (1250) were collected randomly from pregnant women attending antenatal clinic. The blood was separated and stored at -20 degrees till further use. The samples were pooled (pools of 6) and screened by ELISA technique. Individual ELISA was done for samples that were reactive. These ELISA reactive samples were confirmed by Western Blot.

Results & Discussion

Ten (10) pooled sera were reactive for anti HIV antibody. Samples from these pooled sera were retested individually. Ten (10) samples were reactive and confirmed by Western Blot (0.8%)

When individual ELISA is performed 96 tests can be done with one Kit (one BLISA kit costs Rs. 4500.00) whereas when 6 samples are pooled together 552 tests can be done with one ELISA Kit. If 1250 samples are to be screened individually, 14 ELISA Kits are required. But when pooled technique is used only 3 Kits are needed.

KIT	No. of test that can be performed	Cost of the kit
1 ELISA KIT	92 tests can be done	Rs. 4500.00
1 ELISA KIT (pool of 6)	552 tests	Rs. 4500.00
14 KITS	1250 individual ELISA	Rs. 1,25,000,00
3 KITS (pools of 6)	210 wells	Rs. 1,25,000,00
		Rs. 1,04,000,00

Conclusion

Therefore pooling of sera samples is a reliable technique to be used where large numbers are to be tested for HIV. In addition where resources are limited this technique will be useful.

RECENT ADVANCES IN HIV DIAGNOSTICS AND IMPROVED STRATEGICS FOR TESTING

Niel Constantine

Diagnostic tests for the detection of HIV infection have evolved from the classical ELISA and Western blot tests to new technologies that can offer advantages in a variety of testing situations. Among these are included tests on urine and rapid tests that use serum, whole blood or saliva. These have application which can save lives by providing results in a clinically relevant time frame (i.e. occupational exposure or pregnant women where drugs can prevent transmission), and can provide results in 5 minutes with a single procedural step. Combined HIV antigen/antibody test and tests to detect viral nucleic acids can identify infection earlier than classical test thereby helping to protect the blood supply. Rapid confirmative tests can be used in public health clinics and physician offices to eliminate the need for return visits and for instituting

therapy immediately. "Detuned" testing strategies can be used to estimate incidence of infection in order to target the most at risk populations for intervention. Newer tests also incorporate additional antigens in order to detect escape variants of HIV, and some tests can actually identify the specific type and group of HIV. New testing algorithms can result in cost and time savings thereby addressing important issues for developing countries. HIV diagnostics continue to evolve to produce better, more approximate, less expensive, easier performance and more means to assist clinics and to save lives.

DILEMMAS OF INTERVENTION STRATEGIES

Suresh Kumar M, Psychiatrist

Behavioural interventions aimed at reducing the risk for HIV/AIDS are effective and should be disseminated widely. Several factors influence the implementation of HIV risk behaviour interventions. To improve compliance with interventions, the targeted individuals must be involved at every phase of the process of design, development and implementation of the programmes. Programmes need to be culturally sensitive and appropriate and pay attention to age, social class and sexual orientation. Multiple interventions work better than single intervention efforts and periodic interventions are efficacious than once-only approaches. It is important to consider the community myths and challenge them with scientific data to make the interventions acceptable to local communities. Assertions like needle exchange programmes will lead to increase in drug use or increase in injecting drug use or sex education programmes result in early onset of sexual behaviour and/or more sexual partners, or that condom distribution fosters risky behaviour are not consistent with scientific evidence. These programmes apart from being effective HIV intervention programmes have produced desirable outcomes like decline in injecting drug use, delay in initiation of intercourse and lower incidence of risky sexual behaviour.

Despite the private nature of the HIV related risk behaviour, Governments have the options for influencing decisions among those most likely to contract and spread the virus. Coverage is a critical issue in successful prevention efforts and without the involvement of the Government, adequate coverage of interventions are not possible. Public policy can directly influence the individual high risk behaviour, either by lowering the costs of safer behaviour or by raising the costs of behaviour that can spread HIV. Enforcement actions on injecting drug users can exacerbate the epidemic by making it harder to reach those most likely at - risk. Improving access to drugs for people living with HIV/AIDS presents challenges on a variety of levels that include financial constraints, prioritization of drug needs and health care infrastructure.

"THE URBAN JUNGLE :" THE HIDDEN WORLD OF VULNERABILITIES

Anjali Gopalan

In the next millennium India faces a nightmare HIV epidemic. At the same time we are reinventing our society, social norms and identity as a nation. One of the most noticeable changes in today's India is the growth of mega cities and the impact they are having on society. These cities are typified by: Poor and unmanaged planning leading to lack of resources and basic infrastructure, increased pressure on an already overburdened health system, breakdown of the extended family leading to more nuclear families. Individuality is fast replacing the collective response to life. Migration to these cities has increased whether voluntary or forced . These factors make it easy to become "lost" especially for minorities without financial or other supports. People living with HIV/AIDS are already facing discrimination and issues in receiving adequate care and support from society. These changes make PLWHA even more vulnerable, increase the already insermountable pressures they are facing, and reinforce the marginalisation they already face.

HARM REDUCTION PROGRAMMES FOR IVDUS IN INDIA SECOND INTERNATIONAL CONFERENCE ON AIDS INDIA 2000.

Jerajani RN

Injectable Drug Use (IDU). There are very few of them who can be motivated for the treatment as the treatment is perceived as a threat to take away the freedom of drug use, when it is rigid about the strategies of abstinence as the only answer to substance abuse.

The strategies &/or programmes that should be considered for IDUs all over the country, ethnicity and pattern of use, risk perception and risk behaviour of the client, participatory programmes that are cost effective and practical in implementation are the prime criteria for the strategist.

Are we restricting ourselves by bond of paradigms and the narrowness of the vision or we are opon to examine, explore, experiment and enjoy the new millennium with a dimensional approach.

Do we only look at the chemical substance & HIV or do we also look at the person who has had breakdowns and then try to achieve a break through. Totality programmes maintain openness, confidentiality and human touch. Irrespective of type of intervention like clean needles program, needles exchange program, condom distribution, Community based organisation and organised medical help is needed for these patients. Using existing infrastructure of health programs of government should not be the matter of discomfort for NGOs, and develop a healthy network of like-minded people. Here I take the opportunity to suggest the principle of HIV AIDS MANAGEMENT & MONITORING SYSTEM (HAMMS) for all. It is a total management system for the patient afflicted with HIV & Chemical Dependency.

The abstinence may be the Ultimate and ideal goal for the treatment of substance abuser, but at times sounds Utopian.

The Principles of harm minimization are more practical and implementable.

VULNERABILITY OF INDUSTRIAL LABOUR IN THE PRESENT SCENARIO (PRIVATE)

Saraswathi Sankaran

A principal causal factor identified in the spread of AIDS is the individual's lifestyle. Since lifestyle is largely a product of the group that he belongs to, any strategy to control AIDS has to be targeted at specific population groups ``most at risk''. From societal and economic points of view, the most vulnerable are the urban youth, specifically the industrial workforce. In the absence of a cure or vaccine against this virus, combating AIDS, can be only through educating the vulnerable population both at the group as well as the individual levels.

Industrial labour is exposed to several unhealthy social conditions. The territorial, rural-urban group migration, high wage packet, job security, lower levels of education, etc. accentuate the opportunities to lure them into unhealthy practices which place them at risk of infection of HIV, the AIDS virus. Our studies show that the ratio of the organised sector to the general adult population is about 4% in Tamil Nadu and this alone contributes to 40% of the population with high risk behaviour in the comparable age group showing a ratio of 1:10. Therefore, compared to a non-industrial individual, an average industrial worker is more than 10 times likely to acquire HIV/AIDS.

Our study of Indian Railways, the largest employer in India, with 1.6 million on its pay roll, show that the cost to the organisation will run to several crores of rupees per year due to AIDS pandemic.

However, the majority of industrialists today are not considering AIDS as an issue that their industry may have to face some day, sooner or later. Hence the industrial population, though can be easily reached at their workplaces, are still not effectively educated about AIDS.

PROSPECTS TOWARD THE DEVELOPMENT OF AN HIV VACCINE

Juliana M, McElrath,

With more than 33 million cases of HIV - 1 infection reported worldwide and no halt in the epidemic foreseen, there is an urgent need to prevent HIV-1 transmission. To do so will require multiple strategies, foremost being vaccination. No HIV-1 vaccine with proven efficacy currently exists, and the necessary components of an immunogen that can induce protection against HIV -1 infection are poorly understood. Clues have emerged from dissecting the properties of immunity that correspond to protection against other pathogens, and more particularly in vaccine studies in the related SIV/HIV primate models. In addition, persons demonstrating unusual control of HIV-1 infection, e.g., those repeatedly exposed to HIV-1 without overt infection, HIV-1 long-term non-progressors, and HIV-2 infected persons, may have acquired a unique host defense against. HIV that merits induction by vaccination. Building upon these insights, vaccine development has ensured and a number of strategies have been tested in the phase I/II setting. Highlights of these studies and future directions will be presented, with an emphasis on understanding the immune defense that may best correlate with protection.

STATUS OF SIDDHA DRUGS IN HIV INFECTION

Deivanayagam CN

Current Status of Siddha drugs in HIV infection Siddha System of Medicare is a holistic approach to health care practised in Tamil Nadu and Tamil speaking areas of the world, for more than 5000 years. Emphasis is placed on clean life-style, pure air, water, seasonally correct and appropriate diet and when needed carefully processed drugs using herbs, minerals and sea products are utilised to control disorders. Siddha System is based on theory of disturbed harmony of Vatha, pitha and Kapha (wind, bilé, (fire) hlegm (water). This system aims to restore harmony. It is similar to Ayurveda. Assessment of the patient

includes detailed questions, elicitations of symptoms and 8 point examination.

1.TONGUE (TAMBARAM TONGUE).
2.COLOUR
3.SOUND AND SPEECH
4.EYES
5.SKIN FEEL AND HEALTH
6.FAECES
7.URINE
8.PULSE (38 KINDS DESCRIBED).

Role in HIV Infection and Disease

Most manifestation of HIV Infection and disease have been known to Siddha practitioners but perhaps they were not aware of the virus. More than 14000 patients have been assessed at Govt Hospital of Thoracic Medicine since 1992. All have received our recommended Combination of

1.Rasagandhi Mezhugu
2.Amukkara Chooranam
3.Nellikkai Lehyam.

A large number of Siddha practitioners have given their drugs under our direct supervision and control. Small open label trials have been conducted the results will be discussed in detail. Modest impact on viral load (RT-PCR) was noted with drugs given by Dr.Durai. Dramatic reduction in viral load from drugs given by Dr. Vedhanayagam, equally dramatic fall in viral load in Dr. Diraviyakkani's Ice Bucket method will be presented. Preliminary study using Opportunistic Infection Controlling drugs combind with Siddha drugs had shows modest impact on viral load at 5 weeks. This experience of viral control has been confirmed in pilot study I. When OI drugs alone were used (in Pilot II despite good impact on CD4, CD8 counts the viral load increased very significantly- details provided. It was conclued that Siddha drugs allowed that patients to gain weight, largely relieved their symptom and demonstrated viral load reduction. What has not been achieved is reduction below measurable levels of RT-PCR in patients. Neural HIV Infection remains a challenging problem for Siddha system. Research is continuing into the difficult clinical problem.

THE ROLE OF SIDDHA MEDICINE IN THE MANAGEMENT OF HIV DISEASES

Jayaprakash Narayanan P

HIV diseases like Clinical entrities are described in ancient Siddha Medical Literature like "Agathiar Vaidhya Vallathi 600". They have given certain formularies also for managing the diseases. The Siddha Physicians in Tamil Nadu are handling several of such medicines in suppressing HIV Diseases. The paper describes about certain drugs in practice, their efficacy and safety in treating HIV Diseases. These drugs need to be tried with adequate Laboratory Assistance.

A STUDY THE EFFECT OF AYURVEDIC PREPARATION AGAINST HIV INFECTION AND AIDS

Kesavan M

Human Immune Deficiency virus HIV has been conclusively known to be the causative agent for AIDS which is prevalling in all the continents effecting almost 40 million people . The hall mark of the infection is the depletion of CD 4 T lymphocyte population and subsequent collapse of the immunity presently no vaccine or effective medicine has been developed against this disease. In Ayurveda a similar condition "Ojakshaya" has been mentioned in which the fall in immunity may be due to the other patho-physiological condition for which medicine have been prescribed. "Ojas" depletion occurs due to physical and mental causes and "Jeevaneeya Oushadhas" milk, meat soup can counteract "Ojakshaya". HIVinfection leads to breakdown of immunity of the body, but this immunity breakdown does not occur in every one in the same manner. According to the body strength the infected person may be free of symptoms for upto ten years. So it can be ascertained that one may not get AIDS when immune mehanism is infact even if he is infected. "Ojas " is the abstract part of 7 Dhatus. So when there is adequate nourishment both mentally and physically of Dhatus , the

ojas is maintained in the body. Normal function of Dhatus occur only when the Dhatwagnis function normally. We have selected the drugs for AIDS keeping the above points in mind. Four types of drugs are selected for this study. They are Jeevaniya ,Bruhaneeya , Pachaneeya and Raktashodaka qualities. AIDS research was started by the Ayurvedic wing in collaboration with Amala Cancer Research Centre in December 1992. A total number of 210 HIV infected cases, 172 AIDS syptoms cases and 68 full blown AIDS cases were registered by this time and the above four types of drugs were administered to them. Out of these infected cases on whom our medicines are being administered, the full blown cases did not show any improvement by the treatment, but others have responded favourably to the treatment and all of them continue to show progressive sign of improvement in physical conditions and in the body defence system although all of the them continue to be HIV positive in tests done periodically.

SIDDHA MEDICINE IN HIV DISEASE AND A COMPARISON WITH ALLOPATHIC DRUGS

Soundarapandian K

AIDS was reported in the early 1980's in the world. Since then the causative Organism HIV has spread to almost all parts of the world. Efforts are being made to find an effective drug to combat to spread of HIV.

In this process, the cost of allopathic antiviral durgs has become a blue moon for the HIV infected individuals which ulitmatley created a deep insight for siddha medicines, which is used for several hundered years.

Methods & Materials

The subjects of the study were patients attending special ward for HIV/AIDS affected individuals of Meenaskhi Mission Hospital and Research Centre, Madurai. The patients who tested for the HIV confirmation test with Pre & Post test counselling were taken for the study.

The patients who were attending the ward provided with all sorts of health services. The trial patients were regularly monitored and follow-up was undertaken.

Discussion

In this study a total of 25 Patients were taken out of 175 admitted patients. The Cd4 Counts of the patients before and after administering the drugs were keenly monitered. Their weight increase were also observed over a period of 12 months which elicited that there is an improvement in the quality of life and delaying the progreession of infection by siddha theraphy. Similar study also revealed when a group of patients were administered for antiviral drugs exclusively in allopathy. Simultaneously a group of patients were under gone for the combined therapy with siddha and allopathy drugs. The Siddha drugs used for the study were, the combination of Rasaganthi Mezhugu, Chyavanaprasha Legyam, Amukkara Churnam, Thiripala Churnam, Karuvanga Chenduram, Karuvanga parpam, Thirunethieramai and Sandarasa parpam.

Conclusion

In the management of HIV to improve the quality life of the zero positives by gaining weight, improving the Cd4 Count Siddha medicines has a vital intervention with out creating any adverse reactions, involving minimum cost with locally available resourceful drugs. If this research is taken for greater setting, Siddha therapy surely will become the landmark in the combat of HIV virus.

SIDDHA SYSTEM OF MEDICINE IN AIDS

Lakshmi B (S)

The present study deals with the Indian systems of medicine, ie. Siddha System of Literary and Medicinal study of AIDS. Many literatures reveals the Siddha system of medicines to the above disease.

The storm clouds appeared long ago. A great deal has been written about AIDS. A host of hypothesis about its origin are being advanced obviously, none claim to be 100% accurate.

Siddhars whom are the father of Indian System of Medicine have their own view on the development of medicine.

The aetiology and pathology of AIDS is also explained as per the Siddha systems of medicine in the form of poems. The parameters of Siddhars Envagai thervugal, Ezhu udar kattugal, Mukkuttram are very much useful for the diagnostic purpose of the study and to confirm the disease. Drugs are easily available and no side effects.

In the treatment aspect Indian systems of medicine by the name of Siddha Medi- cines are the divine medicine, having a lot of treasure islands in the form of Herbals, Metals, Minerals, Kaya Kalpa Medicines, Yoga and Manthra (meditation) are the high light view of Siddhars to the treatment of multisyndrome disease of AIDS the 20th century plague to come to the end of eradication.

WOMEN NEED MICROBICIDE ACTIVISM TO COMBAT HIV/AIDS

Mark A Wainberg

At least one-half of the world's 35-40 million HIV-infected people are women, and current projections are for the ratio of women to men, infected by this virus, to continue to increase. Over 30 percent of the female populations of sub-Saharan African countries such as Zimbabwe and Botswana, aged thirteen to nineteen, are known to be HIV-positive. Yet, it is perplexing that women's activist movements in virtually all Western countries have not become more fully preoccupied by this enormous and growing problem.

Levels of poverty and despair in many developing countries are such that teen-aged girls are often compelled by their families to become prostitutes in order to help support the family. All too often, these girls may be unaware of the need to insist on condom usage during sex. Even if knowledgeable, they may not be sufficiently empowered to insist on condom usage, if the client threatens to with old payment if condoms are employed. The result, all too frequently, is that these girls may simultaneously become infected by HIV and pregnant, and give birth to an HIV - infected infant nine months later. In fact, 1600 HIV-infected babies are born each day, often to an teen-aged mothers. This highlight that pediatric AIDS in many societies is literally a bi-generational problem. In contrast, relative access to anti-viral drugs in the U.S. and other Western countries, and the use of these compounds to treat pregnant women, virtually ensures that pediatric AIDS will cease to be an important problem in Western societies within the next several years.

The consequences of HIV disease in developing countries are already enormous.

Virtually all of the countries of sub-saharan Africa, because so many women of child bearing age will be lost to the epidemic. For the same reason, and because of the huge burden of HIV- infected babies, life expectancy in these societies will also diminish during the next decade. Moreover, all of this will occur in countries in which access to life-saving anti-HIV drugs is impossible for the vast majority of patients because of cost.

Why then have scientists and the pharmaceutical industry been slow to respond to the obvious need to protect women from HIV, through development of microbicidal products that might be employed as vaginal foams or jellies in anticipation of sexual relations, to kill HIV in ejaculate before it can over cause infection in the first place.

The pharmaceutical industry has been reluctant to do research in this area, because successful microbicidal products, even if developed, would probably need to be priced at levels too costly for the vast majority of women at need. Not only might industry never realize a profit in regard to such products, but the costs of research and development would probably never be recovered either. While international aid agencies and Western governments might be willing to subsidize the costs of such drugs, this might still not ensure that companies would recover the tens of millions of dollars needed to test and prove the usefulness of a microbicide product. Therefore, the executives of such companies might be correct in articulating that shareholder interest mighty not be well served at the present time through commitment of resources to this problem. We urgently need to change the fundamental thinking that leads to this conclusion.

A change in industry attitudes toward microbicide research will not be easy to accomplish, but could be effected with the support of women's activist groups, that could convince companies that their best interest will, in fact, be served by doing work in this area. As an example, women's groups could help to organize campaigns that would favor the female-oriented hygiene products and drugs of companies that do research in this area and, perhaps, by disfavouring the products of companies that do not. Such products include birth control pills, tampons, sanitary napkins, female deodorants, and soaps, and some pharmaceutical companies also manufacture a number of cosmetic products including perfumes and hair dyes. Indeed, the mere threat of such a campaign might be enough to kick-start new initiatives in microbicide research within a short period of time. Current levels of HIV spread around the world are a reflection of past failures by governments, public health officials, scientists, and the pharmaceutical industry. We must act now to prevent even further catastrophe, but any successful campaign to stop the spread of HIV to women at risk around the world will require the involvement and activism of women's groups.

TAMILNADU DR. M.G.R. MEDICAL UNIVERSITY
CHENNAI
HEALTH FOR ALL

POST EXPOSURE PROPHYLAXIS AND MANAGEMENT

Chandrashekar SM

The definition and classification of Post Exposure Prophylaxis (PEP) will be presented. Various common clinical situations reported to be associated with exposure to HIV will be described. Epidemiological data on incidence and prevalence o needle stick injury, injuries due to scalpels and other " sharps"will be presented. Quantification of relative risks of exposure to common pathogens transmitted via blood , plasma , serum , cell concentrates and OPIM {Other potential infective material} will be detailed. Application and practical problems involved in determination of the need for PEP along with the timing of initiation , duration of prophylaxis ,follow up tests will be elaborated. Clinical evidence of efficacy , safety and feasibility of zidovudine and lamivudine in PEP will be described. Standard guidelines on treatment / management of different exposure catagories will be presented. Universal precautions and general measures aimed at reducing the risk of exposure will be elaborated. Institutional ,administrative and individual levels of precautionary measures will be described . Finally the minimum essential measures relevant to Indian scenario will be propsed.

ANTIRETROVIRAL THERAPY IN 2000- IMPROVING DRUG ACCESS

Carl-Heinz Pommer

Effective therapies are now available which can provide clinical benefits for patients infected with the human immunodeficiency virus (HIV). The challenge facing us as we enter the new millennium is how to provide access to and chronic therapy with these antiretroviral (ARV) drugs for people infected with HIV who live in emerging markets countries.

Innovative approaches, including partnerships between industry, governments. and non-governmental organisations are needed to address these complex issues. Prerequisites for effective collaboration are drug availability and affordability, including pricing; training of health care providers; and an efficient drug distribution system.

Realistic strategies focusing on the prevention of HIV transmission offer the most cost-effective approach for developing countries. Prevention efforts should include education, control of other sexually transmitted diseases and provision of condoms as well as prevention of the transmission to the neonates and infants.

Currently, approximately 700,000 children are born with HIV infection every year, worldwide, Prevention of mother-to-child transmission using a simple regimen of nevirapine is a cost-effective strategy that could have a major impact on the numbers of children born with HIV infection. A recent study in Uganda showed that giving a single dose of nevirapine to the mother during labour plus a single dose to the infant during the first few days of life significantly reduced transmission of HIV to the infant. This simple regimen is an affordable option for developing countries-the cost of treating each mother/infant pair is approximately $4 (wholesale price). Implementing this approach could have a major impact on the transmission of HIV to infants and would help to safeguard future generations from this disease.

CHRONIC TOXICITY OF ANTIRETROVIRAL AGENTS

Joep MA Lange

The significant reductions in HIV-related morbidity and mortality in the industrialized world, that have been witnessed in the HAART era, have come at a cost. Toxicity associated with long-term therapy with antiretroviral agents is mounting increasing challenges to chronic therapy. Unfortunately, in the absence of prospects for curative therapy, chronic antiretroviral therapy currently presents our only option to have a durable impact on HIV-related disease-progression.

Chronic toxicities that present the greatest challenge are the so-called ``lipodystrophy syndrome'' (redistribution of body fat, which may be associated with insulin resistance and blood lipid abnormalities) and mitochondrial toxicity (neuropathy, hepatic steathosis, lactic acidosis, myopathy, pancreatitis, a.o). Lipodystrophy has been ascribed mainly to treatment with HIV-protease inhibitors. Mitochondrial toxicity is a known side effect of treatment with nucleoside analogues, and

the consequence of interference with mitochondrial DNA synthesis. A recent hypothesis is that mitochondrial toxicity contributes to lipodystrophy syndrome. Nucleoside-associated hepatic steathosis/ lactic acidosis often have a lethal outcome, but fortunately they are rare (51% of those being treated with nucleosides).

It is of the utmost priority to increase our understanding of these severe toxicities and to identify``antiretroviral regimens that are effective yet safe, even with long-term therapy.

SYNDROMIC MANAGEMENT OF SEXUALLY TRANSMITTED DISEASES: IMPLICATIONS FOR PREVENTION & CONTROL OF HIV INFECTION

Gangakhedkar RR

According to UNAIDS. India has the highest number of HIV infected individuals of all the countries in the world. Current epidemiological picture indicates that the HIV epidemic in India is shifting from a concentrated to generalised epidemic thus affecting the low risk population. The predominant route of transmission in India is sexual. Though the trasnmission efficiency of HIV through sexual route is low, the high frequency of sex acts, rate of partner change and presence of sexually transmitted diseases (STDs) among one of the sexual partners increases it. Our study has shown that HIV-1 DNA shedding is common among HIV infected male STD patients (32 %). However, all the male genital ulcer disease patients (4) in window period were also found to be shedding HIV-1 DNA. The risk of transmission of HIV known to increase by 2-10 times in presence of STDs. Therefore, prevention and control of STDs is crucial in reducing the spread of this epidemic.

The accurate aetiological diagnosis of STDs is difficult to 'be made during the first consultation as the diagnostic tests take some time The differential incubation period may lead to underdiagnosis especially in genital ulcer diseases. One of our studies revealed that the kappa score in genital ulcer diseases is especially lower in HIV infected individuals and

Herpes progenitalis infection is more likely to be missed. Moreover, a significant proportion of patients tend to have more than one STD. Though our studies have shown a lower prevalence of chlamydia infection among patients with genital discharge, it may be common elsewhere. Tendency to undertake polypharmacy and poor drug adherence complicates the management. Hence, management of STDs needs to be done on the syndromic basis rather than aetiological diagnosis. However, syndromic approach is less efficacious in females due to a large proportion of them remaining asymptomatic even in the presence of STDs. Strengthening partner management and making efforts to improve treatment and health seeking behaviours especially among > at risk = women rnay negotiate these issues to some extent. Syndromic management can be a feasible, simple approach to administer treatment for STDs at the first level contact in primary health care set up. The fear of increasing prevalence of drug resistance among STD organisms is not yet well documented. "The experiences in Tanzania have revealed usefulness of this approach extended through paramedical workers in reducing HIV incidence.

In order to strengthen STD management through syndromic approach, training medical practitioners especially the gynaecologists in public and private setting is essential. Additionally, a large proportion of patients tend to seek care from practitioners of traditional medicine. The training must cover them as well. Integration of STD care in primary health care is vital to increase the coverage for STDs in rural areas. Extending counselling to the STD patients and strengthening partner management are crucial in prevention of secondary transmission of STDs and HIV. Establishment of durg resistance surveillance for STDs and surveillance to identify and changes in the pattern of STDs in different regions of the country will be requried to modify the drug combinations in syndromic management, locally. Control of STDs through sydromic approach and efforts to change the risky behaviour will go a long way in prevention and control of HIV infection in India.

"UNANSWERED CRITICAL POLICY ISSUES" RIGHT OF THE HEALTH CARE WORKERS, MANDATORY TESTING AND POST EXPOSURE PROPHYLAXIS

Murali NS, Zafrullah, Krishnamurthy P,

Introduction

HIV and health care workers:-

Health care workers especially those who deal with large numbers of HIV infected patients have the risk of becoming infected with HIV as a result of professional activities. Data from several large studies suggest that the risk of HIV infection following a percutaneous infection with an HIV contaminated hollow-bore needle is approximately 0.3%.

Rights of health care workers

With an increasing incidence of Hepatitis B, C and HIV in the community, health care workers are ever at an increasing risk of catching these in fections.

- Ensure that universal infection control precautions are implemented in health care and other settings involving exposure to blood and other bodily fluids, and the people working in these settings are provided with the appropriate equipment and training to implement the precautions.
- That the state shall get the medicos and their staff handling AIDS patients, insured.
- Surprisingly, everyone does not practice all the principles all the time. Behaviour changes take time to bring about practice changes. Continued education and intervention is needed to sustain the change. Insufficient knowledge about HIV causes a great deal of fear among medical personnel.
- It is not sufficient to train the health care workers on universal precautions when there is not enough funds for providing adequate supplies of protective disposables.

Mandatory testing

It is difficult to reach a consensus on this issue. The diagnostic testing distinctly differs from HIV testing for screening purposes. Who is the ultimate beneficiary from mandatory testing of all patients - the doctor or the patient is an interesting issue. Hospital which follows strict sterilization and disinfection procedures needs no mandatory HIV testing. If at all, a patient needs to be tested, there is no harm in getting their informed consent. Informed consent necessarily implies creating an awareness through pre test counselling. In India health care providers assume implied consent of the patients. Mandatory testing and other testing without prior consent counselling has no place in an AIDS prevention and control programme.

Postexposure Prophylaxis

Most occupational exposures do not lead to HIV infection. Both risk of infection and possible side effects of drugs should be carefully considered when deciding whether to take postexposure prophylaxis.

OCCUPATIONAL HAZARDS TO HCWs

Rajkumar, JS

The spectre of HIV infection now being harsh reality amidst us, it behoves even health care worker to be acquainted with the facts concerning risk of HIV transmission ,relative risk quantification in relation to types of exposure, and post exposure, chemoprohylaxis.

Although most body fluids of infected patients contain the virus, blood and vaginal secretions have the highest concentration. Thus, surgeons and obstetricians carry the highest risk of occupational infection. Percutaneous exposure involving a hollow needle carries the greatest transmission risk, at 0.3%. The increase in active pulmonary tuberculosis in AIDS patients also indicates a higher occupational TB exposure risk for HCWs.

Universal infection control measures are illustrated. These should be instituted in all patients, by all HCWs. Chemical disinfection and soap or betadine handwashes between patients are recommended.

Post exposure chemoprophylaxis is based on 2 drugs or 3 drugs, depending on the degree of risk. HIV transmission shows a marked prejudice against health care workers, with transmission being unilateral (from patient to HCW, and not HCW to patient!)

Finally, the phenomenon of burnout due to work stress, common among HCWs, is also discussed.

MOTHER TO CHILD TRANSIMISSION

Cipriano A, Canosa

HIV mother to child transmission is of great importance to design preventive strategies in order to control the spread of the disease. Actually in developed countries, early identification, diagnosis and implementation of therapeutic strategies have arrested and control HIV transmission from mothers to children. However in developing countries serious difficulties to assure early diagnosis and reliability of antiretroviral drugs are responsible for dramatic and continuous increase of HIV infected children through vertical transmission. Numerous factors intervene in perinatal transmission Maternal placental, fetel, labour, obstetric, new born and breast milk factors should be determine to explain its relative importance on transmission. If HIV transmission will occur during the first, second or third trimester or the time of delivery, therapeutic interventius have to be addressed accordingly. These considerations imply that the diagonstic procedures are available to the target populations. Early prequancy diagonstic becomes critical to prevent consequence of the HIV infected mother and fetus. Specific drug, adequate nutrition, prevention of infections and selective cesaren sections are strategies to prevent HIV vertical transmission - Maternal factors : Maternal disease stage, CD4 counts, vit A levels, specific antibodies, viral load, viral pheno and genotype, and cellurlar immunity are important to control HIV infection, cervovaginal viral load, local HIV specific immunity, Maternal-fetal blood tranfusions. 3-Obstertric factors: Duration of membranes rupture, mode of delivery invasive procedures, intrapartum gential secretions anti HIV secretary. IgA. 4. New born factors: No of fetus (Single, multiple births), skin integrity, birth weight, prematurity, decreased functional immunity, skin and numerous exposure to maternal blood, oral route transmission,

swallowing blood, invasive procedures. Interventions to prevent or reduce vertical transmission has to be addressed to reduce maternal viral load, increase maternal infant HIV specific immunity, therapeutic drugs used during pregnancy and delivery, therapy of the newborn to prevent transmission or to slow disease progresion. To implement all these strategies, early pregnancy and control and delivery and drugs availability care must be secured. The round table will address identification of the feasibility to implement all or part of these strategies.

PATHOGENESIS OF HIV 1 INFECTION IN MOTHERS AND INFANTS

Nafees Ahmad

As a greater number of women in child bearing age group are infected with Human Immunodeficiency Virus type 1(HIV-1), AIDS in children is becoming one of the fastest growing aspects of the AIDS pandemic worldwide. In less developed countries, a significant proportion of all HIV-infected people are children, and it is estimated that one third of all childhood deaths will be due to HIV-1 infection. Perinatal acquired infections account for approximately 80% of all HIV-1 infections in children and infected children develop AIDS faster than adults. Thus, prevention of mother to infant transmission of HIV-1 must be an urgent global health priority. Presently, the molecular mechanisms of perinatal transmissions are not known, which makes it very difficult to define strategies for effective treatment and prevention of HIV-1 infection in children. Although AZT administration during pregnancy has reduced mother-to-infant transmission, but this treatment is not available to infected mothers in the developing countries.

We need a preventive vaccine that could be used worldwide to prevent mother -to-infant transmission. This could be achieved by characterizing HIV-1 isolates that are transmitted from mother -to-infant . This approach has important implications for the development of prevention and treatment strategies because the strategies involved should be targeted at viral isolates with the properties of the transmitted viruses. Our hypothesis is that there are specific molecular and biological properties of HIV-1 that are critical determinants of perinatal transmission. The human immunodeficiency

HIV virus type 1 (HIV-1) sequences from envelope V1 to V5 regions, gag p17, vif and vpr were analyzed from seven infected mother-infant pairs following perinatal transmission. The coding potentials of those regions were conserved in most of the mother infant isolates.

The vs region sequences from infected mothers displayed a heterogeneous population, in contrast to the infants' sequences that' were less diverse than those of their mothers. In addition, the V3 region sequences from the younger infants were more homogeneous than the older infants' sequences. There was a low degree of heterogeneity of gag p17, vif and vpr genes within mothers, within infants, and between epidemiologicaly linked mother infant pairs. However, the distance of env, gag p17, vif and vpr sequences between epidemiologically unlinked individuals was more comparable to epidemiologically linked mother-infant pairs. All infants sequences were different but displayed a similar pattern as seen in their mothers. Based on the V3 region sequence analysis, we found a minor genotype. This genotypes initially predominated in the infants as a homogeneous virian and became diverse, as the infants grew older. The V3 region from mothers' minor and infants' major variants conferred microphage - tropism and non-syncytium inducing phenotypes to the virus (R5 virus. These data suggested that the minor genotypes of the infected mothers with macrophage tropic and NSI phenotypes (R5 viruses) are transmitted from mothers to infants. In addition, several isolates of HIV-1 replicated better in neonatal mononuclear cells compared to adult blood mononuclear cells, suggesting that an increased rate of HIV-1 replication in neonates may contribute to a rapid disease progression. Further analyses of gag p17, vif and vpr genes revealed that the functional domains essential for these protein's function were highly conserved in most of the sequences. A high conservation of intact and functional gag p17, vif and vpr supports the notion that these genes play an important role in HIV-1 infection and replication in mother-infant isolates that are involved in perinatal transmission. In conclusion, the strategies for prevention and treatment of HIV-1 infection should be targeted on these molecular and biological properties of the virus.

EVALUATION OF THERAPEUTIC, PROPHYLACTIC AND SAFETY PROFILE OF THE NOVEL ANTIHIV DRUG PMPA IN INFANT MACAQUES

Koen Van Rompay*, Marta L. Marthas*, Norbert Bischotberger, Niels C, Pedersen

Simian immunodeficiency virus (SIV) infection of rhesus macaques is a very useful animal model of HIV infection to evaluate novel antiviral strategies.

During the past 5 years, we have performed a number of studies with the novel antiHIV drug 9[2(R)(phosphonomethoxy)propyl]adenine (PMPA; tenofovir). This compound, which inhibits the viral reverse transcriptase of both HIV1 and HIV2, has a long intracellular halflife allowing a once daily dosing regimen. Our monkey studies, which helped move PMPA in human clinical trials, have focused on different aspects of PMPA:

1). Therapy: Our studies demonstrated that for infant macaques with established SIV infection, PMPA monotherapy is highly effective in suppressing virus replication. Although viral mutants with 5 fold reduced susceptibility to PMPA emerge following prolonged PMPA administration, PMPA therapy is still active against these viral mutants, as we have currently SIV infected macaque that have been AIDS free for more than 4 years thanks to prolonged PMPA treatment. In contrast, the majority of untreated animals died within a 36 months after infection.

2). **Prophylaxis:** We demonstrated that 2 doses of PMPA are sufficient to prevent SIV infection of neonatal macaques. These results suggest that PMPA may be very effective to reduce HIV transmission from mothers to infants, or to prevent infection following accidental exposure (needlesticks, etc.).

3). **Safety :** Although prolonged administration of a high dose of PMPA leads to kidney toxicity, we have identified a low dosage regimen that is effective and appears safe for longterm administration.

Conclusion

Our studies in monkeys suggest that PMPA will be a very effective antiviral drug, even when used as monotherapy. PMPA (tenofovir) is currently in phase II clinical trials in HIV infected adults in the USA, and preliminary results demonstrate that PMPA therapy for 612 months is highly effective and safe. Trials, are being planned to also test the potential of PMPA to interrupt mother to infant HIV transmission.

ADMINISTRATION OF AZT TO UNREGISTERED MOTHERS PRIOR TO CAESAREAN SECTION

Parameshwari S, Mallika K, Mini J, Anandakannan K, Samuel NM

Background: Mother to Child transmission of HIV can occur during pregnancy, at the time of delivery and after birth through breast feeding . The majority of infections appear to occur during labour. So, simple and affordable intervention strategies are needed to reduce the rate of HIV Transmission from mother to infant in developing countries.

The Prevalence of HIV infection among pregnant women varies from place to place like Vellore, Chennai, Pondicherry, Mumbai and Pune. The prevalence ranges from 0.6 % to 4%.

Department of Experimental Medicine and AIDS Resource Centre of Tamil Nadu Dr.MGR Medical University, from January to October 1999 screened 2,250 pregnant women from out patient (AN) clinics and labour wards of various Govt. Hospitals in Chennai and Namakkal. Zidovudine prophylaxis to reduce the perinatal HIV transmision became the standard of care in many developed countries, we also Intiated AZT as a intervention for 23 HIV +ve pregnant women. Initially, 16 pregnant women, were given ACTG076 regimen. The results were discussed in previous papers. In the outskirts of the city, many young women come and deliver at the labour ward directly without any previous antenatal checkup.

Objective

To Initiate Interventional therapy and to reduce the transmission of HIV Infections even for unregistered mothers who were diagnosed HIV +ve just before delivery.

Methods

After counselling and getting a written consent 7 pregnant were recruited from Namakkal. Pregnant women who come with labour pain or to deliver in the last trimester were routinely screened for HIV by spot Elisa. Those who were positive for HIV were posted for elective caesarean section. AZT was administered prior to surgery and for 1 week after the delivery for the mother. For the baby AZT syrup was given 4mg/kg twice a day for 1 week. Mother did not breast feed. Blood was collected from mother for HIV status confirmation and for viral load performed by RTPCR. The Infant was followed for 18 month period.

Results

All the 7 pregnant mothers were housewifes of lorry owners cum drivers. The belong to middle socio economic status. The age group was between 19 to 23 years. Among the 7 five of them were primi gravida while 2 of them were II nd gravida. Among the 7,3 had vaginal wart. Among the 7 five of years old women had a huge vaginal wart (a big mass) hanging from the Right side of the labia majora. Data on the viral load of the mother and baby will be discussed during presentation.

Conclusion

Elective caesarean section with AZT prophylaxis and avoidance of breast milk can achieve, complete reduction of HIV infection from mother to infant. This study was undertaken to show that women diagnosed HIV +ve at the time of labour can be benefitted with AZT to reduce the transmission of HIV infection.

NEVIRAPINE-A NEW STRATEGY TO PREVENT MOTHER TO CHILD HIV TRANSMISSION

Mark Mirochnick

Nevirapine is a non-nucleoside reverse transcriptase inhibitor with several qualities that make it ideal for the prevention of mother to child HIV transmission. Nevirapine is well absorbed with oral dosing, has a long half-life and is extremely potent against wild type HIV. It is well tolerated with minimal toxicity following single dose use. Nevirapine can penetrate cell free virions and inactivate virion associated reverse transcriptase in situ. Pharmacokinetic studies have shown that administration of a single oral dose to the mother during labor and a single oral dose to the mother during labor and a single oral dose after birth to the infant maintains serum nevirapine concentrations in the infant more than 10 times greater than the IC50 against wild type HIV throughout the first week of life. In a study in Uganda, this nevirapine regimen reduced mother to child HIV transmission by 50% when compared to an equivalent AZT regimen. The two dose nevirapine regimen is an effective yet practical method to reduce mother to child HIV transmission when health care resources are scarce. Further studies are underway to evaluate the efficacy of prolonged newborn nevirapine dosing in preventing breast milk-HIV transmission.

CHALLENGE OF MANAGEMENT OF PEDIATRIC HIV INFECTION

Rashid H Merchant

As the cases of Acquired Immuno Deficiency Syndrome (AIDS) spread the world over, in the late 80's and 90's physicians at the Wadia Children's Hospital began to encounter children who fitted the clinical definition of AIDS. It was then decided to screen all pregnant women voluntarily for their HIV status with an objective to determine the seroprevalence in this low risk group. To date, 80,000 pregnant women have been screened from January'93 to October'99, with seroprevalence rates as shown in Table- I. Since the essential of a socially, sensitive screening service also required education and counselling, the Perinatal clinic was started in 1994. Anti-retroviral therapy (ART)became available in Mumbai in middle of 1995. We then began to offer ART as a means to reduce perinatal transmission and soon devised an interventional model, popularly called the ``Wadia Initiative'' which has successfully reduced the mother-to-child transmission (MTCT) to 4% . The essence of this model is shorter duration and lower doses of antepartum zidovudine (AZT), delivery by elective Caesarian Section, AZT to the baby and no breast-feeding. We started the Pediatric HIV clinic in 1996. Presently, we are following 240 HIV infected children of whom 75% are below the age of five years and 88% are perinatally infected. Table-2 shows the clinical manifestations in our patients. We offer family screening, counseling, emergency services, and hospitalisation, treat opportunistic infections and have regular follow-up. However due to financial constraints, we have been able to offer ART to only 15 children, of whom 11 are on 2 drug regime (AZT+3TC) and remaining on 3 drugs (AZT+3TC+PI). Their mean pretreatment CD4 count has been 330 cells/mm3 and the mean pretreatment viral load has been 1,16,000 copies/ml. They are being clinically and immunologically monitored. All have shown good clinical improvement and increase in the CD4 counts. So far no adverse drug reactions have been noted. The Wadia Program aims at a holistic approach to contain the surge of HIV/AIDS in this vulnerable population of women and children.

Table I - Results on samples tested for HIV in pregnant women at the Wadia hospital

Period of testing	Patients tested N=71739	patients reactive n=964	Percentage %
JAN - DEC 93	12436	95	0.76
JAN - DEC 95	12354	114	0.92
JAN - DEC 96	12250	204	1.66
JAN - DEC 97	1107	153	1.40
JAN - DEC 98	12065	287	2.37
JAN 93 - DEC 98	71739	964	1.34

This table shows a gradual increase in seroprevalence of the so called "low risk" housewives in inner city area of Mumbai metropolis indicative of the magnitude of the problem.

Table - 2 Signs and Symptoms associated with HIV Infection (n=240)

Failure to failure	111 (46.25%)
Tuberculosis	72 (30.00%)
Hepatosplenomegaly	(69 (28.75%)
persistent generalized lymphadenopathy	55 (22.92%)
Skin lesions	53 (22.08%)
chronic diarrhea	37 (15.42%)
Oral thrush	37 (15.42%)
Pyrexia of unknown origin	34 (14.17 %).
Chronic lung disease	28 (11.67%)
Chronic parotitis	20 (8.33%)
Lower respiratory tract infection	15 (6.25 %)
CNS manifestations	13 (5.42%)
Asymptomatic	48 (20.00%)

BREAST MILK TRANSMISSION OF HIV-1 : AN OVERVIEW AND CONSIDERATIONS FOR POLICY AND FUTURE RESEARCH

Grace C. John MD, MPH

Several promising interventions to prevent mother-to-child transmission of HIV-1 have been identified in the last decade. These include antiretroviral therapies (short-course AZT, AZT/3TC and nevirapine), avoidance of breastfeeding and caesarean section. While these interventions are clearly effective, it is important to understand the challenges associated with widespread implementation at policy level and the considerations that regions must consider in designing programs to prevent infant HIV-1 infection. In this session of the symposium we will review perinatal HIV-1 transmission, focusing particularly on breastmilk transmission of HIV-1 and will consider issues related lo feasibility of interventions that are regionally dependent.

The risk of breastmilk HIV-1 transmission is 16% and contributes to almost one half of infant HIV-1 infections among infants born to HIV-I infected women who breastfeed their infants. Cofactors for breastmilk transmission include maternal plasma viral load, mastitis, and breast abscess. Alternatives to breastfeeding may be risky to infants and associated with increased infant mortality if not implemented carefully with attention to provision of safe water for reconstituting formula and a consistent adequate supply of breastmilk substitute. Approaches to preventing breastmilk HIV-1 transmission include complete avoidance of breastmilk or early cessation of breastfeeding. It remains important to identify new methods to decrease breastmilk HIV-1 transmission among HIV-I infected women who choose to breastfeed. Potential options include infant prophylaxis with antiretrovirals while breastfeeding and promotion of 'safe' breastfeeding practices (exclusive breastfeeding or avoidance of breastfeeding from a breast with mastitis or abscess). The fact that the minority of infants exposed to breastmilk HIV-1 is infected despite persistent exposure also raises the possibility that acquired immunity may be protective and ultimately replicable by vaccination. Further studies to identify correlates of protection from breastmilk HIV-I transmission will be essential to develop widely feasible options to prevent transmission via this route.

BLOOD BANK & TRANSFUSION SERVICES

Vimala Ramalingam

The Government of India has set the goal that every state in the country should have supplies of blood and blood products that are safe as possible, accessible at reasonable cost and adequate to meet the national needs. Its strategy for achieving the goal emphasizes the importance of

1. Reducing the proportion of unsafe blood that is collected

2. Building up a panel of voluntary non renumerative donors who are willing to donate blood regularly, since these are the foundation of safe blood supply

3. Where a panel of regular voluntary donors have been established and careful screening and selection procedures are followed , some donors will prove to be seropositive for HIV or other infectious agents All donated blood must therefore be screened to ensure safety of the blood supply.

4. Patients some times die following a blood transfusion as a result of errors in blood grouping or compatibility testing or because the blood or plasma has been selected or issued incorrectly. It is therefore essential that laboratory technical staff understand the basic scientific principles underlying their basic serologic work, perform tests accurately and are able to interpret the results accurately.

Are we assured of safe blood ?

Dolly Daniel

With increasing awareness , the fear of the repurcussions of a blood transfusions is on the increase. Within our limitations of the cost effectiveness. We strive for the "safest" blood that we can issue from a blood bank. But "safest" we all know is not totally safe. Where are we heading ? Where do we set our limits ? - Perspectives from a referral hospital in South India.

PROBLEMS ENCOUNTERED IN BLOOD DONORS

Rema Menon

The blood transfusion system is dependent almost entirely on the blood donors. Transfusions can be safe only if we have voluntary, low risk, repeat donors. It is therefore the duty of the transfusion services and the health care providers to be sensitive to the problems encountered in blood donors and to address these issues and to ensure the availability of safe blood in our blood banks.

I discuss herein the problems encountered in blood donors and the possible solutions to the same.

BLOOD DONOR RECRUITMENT - INNOVATIVE IDEA

Jaju NB, Kumthekar N, Sunita Amonkar

Issue

In India 40% blood is collected from Voluntary blood donor and 60% from replacement donors. Ignorance, unawareness and fear of weakness and AIDS are the major causes of this dismal situation.

Background

Blood from voluntary donors is much safer than replacement donors. Supreme Court has directed to eliminate professional donors, to phase out replacement donors and to achieve 100% voluntary donation by motivation.

Objective

The aim is not to test the prevailing knowledge of the college students but to create awareness of blood donation through open book quiz contest and award fabulous prizes.

Design & Method

A book with 80 optional questions carrying 1 mark each and 2 subjective questions carrying 10 marks each (Total 100 marks) is

prepared. Each question has 3-4 optional answers and the student has to tick the correct one. Two subject questions are about no. of blood donations and slogans respectively.

Students carried home the questionnaire and returned after 4 days. Model answers were provided to each college for evaluation. Several N.G.O.'s extended whole-hearted co-operation in this huge task.

Results

Will be discussed

Conclusion

Blood donation awareness program for the youth is a grand success by specifically addressing to facts and myths in challenging, recreationary, cost effective and informative mode of "Open Book Quiz Contest".

SAFE BLOOD

Radhakrishnan KM

Blood Transfusion and its components are associated with an inherent risk of transmission of blood borne infections. Hence it is absolutely essential to ensure safe blood supply to the needy.

Blood and its importance -Requirement -Strategies to prevent transmission of infection through blood

Safe donors-Safe Blood Transfusion
Safe blood product and viral inactivation procedures
Appropriate & rational use of blood -Effective quality assurance.

Donor motivation and its approach - Stringent criteria for donor selection - Infections transmitted through unsafe blood - Safe blood products - Viral inactivation procedures - Cellular components - Appropriate and optimal utilization of blood Autologus blood transfusion - Blood sparing strategies - Constitution of Hospital Blood Transfusion Committee - Quality Assurance. Active interactions between Blood Transfusion Dept. and Clinicians.

CULTURAL ISSUES AFFECTING COUNSELLING, CONFIDENTIALITY-AND INFORMED CONSENT

Prathap Tharyan

Infection with HIV has become the scourge of the 20th century and the lack of widespread availability of effective remedies in resource poor countries suggests that HIV and AIDS will continue to wreck, havoc in the lives of many well into the 21st century Counselling remains the only available option to mitigate the distress of people of affected people and to reduce transmission of the virus.

Counselling people with HIV/AIDS or those at risk raises many ethical issues that are often at variance with the sociocultural milieu of societies in the developing world. Societal prejudices to these affected reflect their prejudices to the practices that led to the infection and have led to the rejection, marginalisation, ostracism and denial of care of millions of affected individuals. Low levels of literacy inadequate reach of awareness campaigns, misconceptions regarding the spread of the infection and conflicting models of disease and health care add to the stigmatisation of affected individuals and the inefficacy of prevention and control programmes. The primary challenge to provision of effective counselling for people with HIV/AIDS is the recognition and acceptance of diversity in society and respect for alternate viewpoints regarding sexuality. sexual behaviours, gender roles, and individual autonomy. Social prejudices demand that health care services view HIV infection differently from other infectious diseases. The traditional paternalistic approach to health, care needs to be tempered by a more patient centred approach with primacy given to the ethical principles of respect for the autonomy of the affected individual, beneficence and non-maleficence

Central to ethical practices are the doctrines of confidentiality and informed consent, but there are many attitudes inherent in the fabric of our society that challenge these doctrines. Unlike the ethos of life in the West where self-determination and privacy are cherished facts of life, in

south Asian countries individual desires and, decision making are subjugated by the dictates of common affiliations to families, communities, religious traditions, gender and trans-generational roles. Models of medical practice have approximated the traditional Guru-chela relationship, as opposed the contractual model followed in the West In the contractual model the physician and patient enter into a contract seemingly of equals rather than the dependence that characterises human relationships in the Indian subcontinent in general and the physician patient relationship in particular. Hence the derivative principles of confidentiality and informed consent which flow from respect for autonomy are often honoured more in the breech than in the observance in India. However developing economies are societies in transition and challenges to paternalism are increasing, demanding a culturally appropriate response from health care providers.

Questions of distributive justice or how health care is allotted equitably pose additional problems as it shifts the focus from the traditional obligations of physicians and counsellors towards their orients to the rights of society. In the counselling framework, many situations abound where balancing the relative rights of each may strain the ethical skills of even the most experienced clinician or counsellor.

Ethical values have often been influenced by and influenced legal doctrine and legal principles are closely related to ethical principles. The recent Supreme Court ruling on the limits of confidentiality in HIV raises many ethical issues that demand resolution in the near future. No legal doctrines exist in India to regulate the right to informed consent in research and practice and the ethics of research in vulnerable populations is of utmost concern the world over. This paper examines these issues in the context of the care and advocacy of HIV affected peoples living in India and proposes guidelines for deliberation and debate.

DILEMMAS OF AN OBSTETRICIAN IN A RURAL CLINIC ON "WHAT TO SAY & WHAT NOT TO SAY" COUNSELLING AND CONFIDENTIALITY

Aarthi S, Lakshmi

Terms that have been distorted by the effects of crumbling economies, illiteracy and socio-cultural barriers have deprived the Indian woman, the supportive hand that could lead her into the information age of health care today.

Topics Of Discussion

a) The increasing risk of HIV faced by women

b) Economic and socio cultural barriers at the rural scenario

- Significant gender bias & power differential.
- Reliance on monogamy & mutual fidelity.
- Womens' inability to negotiate safer sex practices independently.
- Economic dependence of women on men

c) Myths & realities of rural practice

-At present, the public awareness of HIV, largely due to audio visual media has increased anxiety without increasing the level of people's knowledge.

d) Responding to reality Agenda for action

- Reproductive health services are an excellent entry point.
- To break the ice," A well organized and motivated family practice, an ideal setting for a counselling clinic where couples pregnant, planning a family, and school leavers could receive information on general health and well-being.
- Though it should be ideally undertaken by medically trained, considering economic constraints, training non medical staff seems to be the logical answer.

- Target the hardest hit group -youth by providing health & sex education at schools.
- Getting more men to be involved & counter the gender discrimination.
- Ensure maternal and child health clinics are well equipped to diagnose and treat STD.
- Encourage voluntary confidential HIV screening in pregnancy
- Increase the availability of support services for HIV positive women.
- Ensure strict implementation of universal precautions in all obstetric centers

"From cursing the darkness of poor resources, are we prepared to light the candle and make, health care & cure a reality for Indian women"

SPECIALIZED MEDICAL NEEDS FOR HIV-AIDS PATIENTS

Saple DG

Many times patients do not get proper information regarding When to suspect HIV; How to confirm the Diagnosis; What is the prognosis of the disease; What are the various Treatments available; Proper knowledge about Anti Retroviral Therapy (ART) Safe guard from quacks; How to prevent HIV in terms of Mother to Child Transmission (MTCT), Blood transfusion, Needle Stick injury and Sexual transmission.

In a country like India where people totally depend on Doctors, the first priority is to train Medicos and Paramedicos regarding HIV since Statistics about HIV awareness suggest that in Mumbai itself, only 0.1% Gynaecologists are aware about Mother to Child Transmission & 0.2% Medical Practitioners are aware about Post Exposure Prophylaxis (PEP).

It is not possible to point out all pitfalls in HIV practice, in this abstract but I would like to mention a few examples. As far as Diagnosis is concerned, in a city like Mumbai every patient, irrespective of their Financial status is

advised Western Blot test which costs about Rs 2000 to 2500, where a sensitive and specific ELISA is enough for diagnosis. The p24 antigen detectable in early and later stages of HIV disease, remains undetectable during the asymptomatic or latent phase of HIV disease and this has been exploited by quacks. About Prognosis of the disease, many doctors are not aware of the natural course of the HIV disease and wrongly label patients in Asymptomatic stage as AIDS patients. As far as the treatment is concerned, do not say that there is no treatment which leads to patients landing up with quacks. HIV-AIDS is treatable like Diabetes and Blood pressure. with the help of ART, patient is expected to survive for about 10 years or more. Patient should be given proper information regarding ART -- When it should be used, What are the combinations to be started which depends upon the availability, affordability, prompt effect of the drug to supress HIV to undetectable levels and to sustain it for a prolonged period with minimal side-effects and convinience for patient to adhere to the treatment. Ideally 3 drug combination is effective but 2 drug combination can be used with limitations. Drugs like Hydroxyurea can be used as a third drug which many people can afford. During Monitoring of ART, CD4 and Viral loads should not be advised when patient is suffering from illnesses like Influenza where the levels can be misleading.

ART is very useful for Prevention of HIV transmission from Mother to Child which can be brought down from 40-70% to 8-1% with the help of AZT and Nevirapine. Post Exposure Prophylaxis (PEP) is effective for Needle stick injury in Health Care Workers, Sexual contact with an Unknown person and Condom tear. The prompt and peorper treatment of Opportunistic Infections (O.I.) and Prophylactic treatment at the right time will prolong and give better quality of life. e.g. In India the main O.I. is Tuberculosis which is preventable and treatable. In Alternative Medicine, some doctors are claiming that Ayurvedic medicines are useful to increase the immunity to some extent but patients have to be careful about the authenticity. Status of vaccine -- Though commercially unavailable, extensive research is being carried out.

CASE MANAGEMENT OF HIV/AIDS PATIENT IN A RURAL SETTING

Manoharan G

Principles of Management

a) Counselling and education
b) General measures
c) Treatment/Prophylaxis of opportunistic infections
d) Specific anti-retro viral therapy

A. Counselling and education

The above measures are very important in reducing morbidity in HIV/AIDS persons. Patients should be aware of

a) The potential transmission of their infection to others
b) Safe sexual practice and
c) The physician must educate the patient regarding the natural history of their illness. The therapeutic decisions should be made in consultation with patient

B. General Measures

i) The Nutritional status of the patient should be improved.
ii) The treating physician should be sensitive to the positive person's fears and concerns.
iii) The psycho-social attitude should be improved.

C. Treatment/prophylaxis of Opportunistic Infections

Once the HIV positive status is confirmed, thorough clinical and laboratory examination should be performed, to determine the extent of the HIV disease, presence or absence of opportunistic infection and to learn a baseline standard for future references.

D. Anti - retro viral therapy

The specific anti-retroviral therapy is the corner stone in the management of HIV infection. Suppression of replication of HIV virus is important in prolonging life and also in improving the quality of life.

Anti-retroviral Drugs

The drugs fall into 3 groups viz;

a) Nucleoside reverse transcriptase inhibitors (NRTI)

b) Non-nucleoside reverse transcriptase inhibitors (NNRT)

c) Protease inhibitors (PI)

Guidelines In Anti Retroviral Therapy

a) The drug regimen has to be highly potent to suppress the replication of virus

b)The regimen should be initiated early in the course of disease.

Rationale for combination Therapy

a) It is important to note that none of the currently available antiretroviral drugs can eradicate the infection but, in combination, they can suppress viral replications, improve the immunological status.

b) Selection of ante retroviral regimen

The following factors influence the choice of the particular regimen:-

1. Tolerability
2. Past clinical history (Peripheral neuropathy, Anemia,Pancreatitis)
3. Metabolic interactions
4. Pharmacokinetic interactions
5. Potential for cross - resistance
6. Convenience of administrations
7. Action in different type.

Conclusion

At present, in our part of India, the main approach, of a HIV patient attending our Government Hospitals are as follows:

a) Nutritional and psychological support
b) Counseling and education
c) Prevention and treatment of opportunistic infections

In future we hope we can treat our HIV/AIDS patients with anti-retroviral drugs.

CAN HIV POSITIVE WOMEN EVALUATE THEIR NEEDS?

Manorama P

HIV Positive Women & Their Mind Set

She discusses statistically from her experience, the backgrounds of the HIV positive women & their mind set.

Their Problems

Based on her 6 years experience in this field, she discusses comprehensively the problems faced by the HIV positive women in dealing with their issues which are of great importance and considered as "barriers "viz.,
Ignorance
Low Awareness level
Illiteracy
Their poor social background
Heavy dependence on their family leading to low health seeking behaviour
Lack of relevant medical facilities
Cultural beliefs.

Their Needs

Acceptance the HIV positive have unique needs in society & homes.
Medical Care
Adequate job facilities
Opportunity to air their demands.
Isurance & loan facilities.

The Present Scenario

She also discusses, the present status of HIV positive women with the society, how far has the discrimination been broken down,how far is the acceptance.

The Future

She envisages a future wherein, the HIV positive women will be accepted without any qualms in the society.

Conclusion

Concluding, the author says that though at present HIV positive women, need help in evaluating their needs especially from the Government & Non-Government section, she hopes that in the future, HIV positive women would be emancipated enough to evaluate their needs.

TARGETED INTERVENTIONS FOR HIV/AIDS PREVENTION -THE NEED OF THE HOUR

Krishnamoorthy

HIV has been spreading at an alarming rate in India and the prevalence of HIV among certain groups of individuals is a concern to the policy planners and administrators of health. The spread of HIV/AIDS is a challenge to health and development of the country. Recent studies indicate that HIV virus is spreading to the general population and to the rural areas. In this context one has to decide the strategies to be followed to prevent the further spread of infection.

AIDS Prevention and Control Project [APAC] has identified four major thematic intervention strategies to reach HIV vulnerable groups and has been implementing projects in Tamil Nadu since 96-97. APAC has supported eleven projects for intervention along the highways covering major highlight points. APAC has supported intervention projects for intervention among women in prostitution, in tourist places and also intervention among slum communities.

The experience of APAC indicates that highly mobile groups and vulnerable individuals living in small towns and urban settlements could be targeted with specific messages, STD services and condoms for an effective intervention. Collaboration with local health care providers, condom stockists and government agencies in the area improves the quality of interventions.

APAC's efforts has resulted in a significant behaviour change among long distance truckers ,their helpers and women in prostitution. The percentage of truckers and their helpers visiting non-regular sexual partners has decreased from 48% to 32% over a period of two years. The percentage of truckers using condoms has increased from 44% to 66%. A positive behaviour change in seeking treatment for STD conditions have also been observed among truckers. APAC has observed that the condom usage among WIPs has increased from 56% to 80% in two years.

APAC experience supports the view that targeted interventions are necessary to arrest the epidemic. The models developed by APAC are worth replicating in other parts of the country.

A POSITIVE RESPONSE BY LOCAL BUSINESS COMMUNITY

Amanda Murphy

Description

Teddy Exports began in 1991 with 5 unskilled labourers and today it employs over 300 people including those who are HIV positive. We put half our profits into a trust, the Teddy Trust, which runs a school, a clinic, a non-formal education project and AIDS Project.

The AIDS Project began with one persons by name Geetha aged 22 HIV positive with no where to go , found on a routine visit to a government hospital. We now have three truck booths providing condoms and information for over 80,000 truckers today. We have shared our resources with other NGOs and run two STD clinics at low cost. Our links with the MGR Medical University provided limited treatment to those in our care. We provide financial support to other NGOs who have been stumped for funding due to the corruption involved in the area and we run a women's project providing STD treatment, counselling and a safe haven for women in prostitution in Madurai city.

We have also built 2 foster bungalows to provide for the everyday needs of the children of HIV+ve people in our care. We have conducted an awareness programme in over 150 local schools and colleges. We

use puppets made from rubbish to street plays so our programmes are low cost an eco friendly.

Conclusion

In 1998 , Amanda was awarded an MBE for her work in AIDS Awareness in India and has proved that the Teddy Exlport/Teddy Trust's model is sustainable and replicable.

OPTIMISING CARE FOR PEOPLE LIVING WITH HIV : HUMAN, ECONOMIC AND THERAPEUTIC STRATEGIES

Yasmin Hailma

Objectives

The work of the EATG and ECAB has been instrumental in promoting wider access to information and better treatment. This model of activism is described as an effective catalyst towards positive change at three levels: (I) our understanding of HIV. (II) the promotion of safer behavioural practices and (III) access to appropriate treatment for all affected communities.

Methods

The EATG (founded in 1991) has established strong working relationships with officials of NGOs and governments, health authorities and the pharmaceutical industry. We have formed an ECAB within which members from HIV/AIDS affected communities collaborate with researchers, clinicians and pharmaceutical companies with the following aims: (I) to review and influence the ethics and relevance of clinical trial designs, (II) to monitor ongoing trials, (III) promote best practice procedures and (IV) interact with investigators and patient communities. Through regular training seminars, participants learn basic HIV disease, pathogenesis and treatment, together with skills that help develop effective and Informed advocates for people living with HIV and AIDS.

Results

Cooperative structures involving people affected by HIV/AIDS can and does play a major role in promoting access to efficient treatment and care. As well as the basic human right assertion that values life without illness, stigma or fear, there is also a profound economic benefit to be gained from directed investment in health care infrastructure. Activist bodies such as ECAB also have a responsible role in supporting the development of transferable models of activism and multiagency collaboration, relevant to the needs of communities in India.

Conclusion

Cost effective strategies for HIV treatment can be developed. To share and maximise these opportunities necessitates meaningful alliances between the wide range of agencies responsible for improving the health, social and economic milieu of affected communities globally.

THE GLOBAL CHALLENGE OF HIV DISEASE ADVANCING SOLUTIONS THROUGH PUBLIC AND PRIVATE SECTOR PARTNERSHIPS

Constance L Blowers

HIV disease emerged nearly two decades ago and has become the most dramatic and tragic epidemic in recent history. It has provoked a reassessment of society's approaches to public health strategy, allocation of healthcare resources, medical research and sexual behaviors. The question now is whether research, behavior modification and education requiring international cooperation, will be able to meet the AIDS challenge.

Current global economic concerns further complicate the approach to the problem. There are considerable social, ethical and political pressures on government spending for economic and social development in addition to public health programs. Further, faced with competing demands for funding from low per capita healthcare budgets, HIV/AIDS is still not widely recognized or acknowledged as a public health priority in some countries.

The unique characteristics of HIV disease present an even greater threat to the world's population. It continues to spread rapidly with an estimated 16,000 new infections each day and there is little evidence that it has reached a plateau. Mainly transmitted through sexual intercourse and injection drug users, varying cultural norms make these behaviors difficult to change or even openly discuss within most societies. The long period (~10 years) from asymptomatic HIV disease to AIDS development contributes to the complexity of effective management and control; this has made it difficult to reinforce the seriousness of the epidemic and the urgency of behavior modification. In addition, intensive research on the virus to develop effective, treatments has resulted in the discovery of drugs -over a dozen in three different classes - which, while representing significant advancements and offering hope to people with HIV/AIDS, are not yet a cure. Treatment regimens for the disease remain difficult and costly involving complex combinations and schedules of drugs administered with or without food. Patients need careful and close monitoring of viral load, tolerability and drug interactions, all of which require sophisticated medical equipment and trained staff.

Current scientific opinion is that an effective vaccine may provide the ultimate answer to the disease but that it is many years away from being a reality. In the interim, prevention education and treatment are the most viable defenses for those affected today, and have the greatest potential to slow the spread of the disease by preventing new infections. Even more fundamental to the prevention of disease is social and economic development to improve standards of living along with effective public healthcare systems. Given the magnitude of these objectives, the responsibilities to ameliorate them are necessarily broad, falling on both the private and public sectors and requiring the development of integrated, comprehensive national programs. Without the political will and resource to build infrastructure to implement comprehensive programs, simply providing supplies of medicines cannot resolve the problem. A collaborative multipartite approach that engages all affected sectors of society is necessary to accelerate progress in this effort.

EMPOWERMENT FOR WOMEN FROM WOMEN THROUGH COMMUNITY ADVISORY BOARDS (CABS) HEIDEMARIE

Kremer (Germany) and Yasmin Motala (UK)

Background

Women account for half of all HIV infections globally. Yet they represent only 10 % of participants in clinical trials, and only 4% receive access to therapy. Women's social experience of HIV disease reflects issues of inequality and injustice. Physiologically, the clinical community is only now beginning to understand and report the complex genderinediated pathogenesis of HIV disease. The steady increase of HIV infection in women and the concomitant risk of matemofetal transmission, reveal disturbing demographics that will remain a concern into the new millennium. Developments in ART have also enabled women with HIV to live better and longer. Its most marked impact has been on the reduction of mother-to-child transmission, which can be reduced to below 2% with optimal standard of care, although we still lack longterm data of the potential damage to children exposed to ART in-utero. Little is known about the longterm toxic side effects of ART in the male body, and even less so in women.

Subject

How can women help themselves?

Methods

Knowledge gives hope. Community and scientific research initiatives across the world are developing our understanding of the needs of women living with HIV. Community Advisory Boards (CABs) play a significant role in the shaping, sharing and implementation of support strategies for women, by women. By challenging and contributing to the quality of care that women receive and discussing clinical study protocols, CABs fulfill a significant role in the empowerment of women. CABs universally share some basic fundamental values, but in order to be effective at local level, each CAB must define its own structure and role based upon the unique demands and circumstances of it medicosocial and cultural context.

The European CAB is establishing its own XXstudy group (XX labels the female chromosomes) to embark on a programme of focused learning and constructive intervention.

Results

In addition to knowledge supply, CABs serve as an effective mechanism for growth, change and healing for the participating women. Stories of CAB representatives illustrate the ways in which participating on the CAB have transformed the lives of women. Some have been able to overcome lives of anonymity, isolation and dependence, whilst others to defeat feelings of fear, hopelessness and powerlessness.

Conclusion

CABs play an important role in empowering individuals and communities, ensuring that research and clinical practice remains responsive to the needs or all its target population. By building Knowledge and solidarity, CABs help women to develop into strong advocates for themselves and for other women infected with and affected by HIV.

DIAGNOSTIC VALUE OF MEASURING IgG ANTIBODY TO LIPOARABINOMANNAN (LAM) ANTIGEN IN PATIENTS WITH PULMONARY TUBERCULOSIS

Alamelu C, Jegannath K, Anandakannan K, Samuel NM

Objective

To evaluate the clinical value of ELISA using LAM antigen as serodiagnostic test for pulmonary tuberculosis (PT)

Design

ELISA test based on LAM antigen of M.tuberculosis was used to estimate IgG antibodies in 153 patients with active PT (of whom 125 were culture proven), 89 patients with non-tuberculous lung diseases (NTs), 90 healthy household contacts and 235 healthy normal adults who were entered into the study from tuberculosis centres in Chennai and from a private blood bank in Chennai.

LIBRARY
TAMIL NADU DR. M.G.R. MEDICAL UNIVERSITY
CHENNAI
HEALTH FOR ALL

Result

Antibody level to LAM antigen was significantly elevated in tuberculosis patients when compared to normals ($P<0.0001$). There was no difference in antibody levels in patients according to severity of disease as assessed by radiology or bacteriology.

79 of 125 culture proven tuberculosis patients showed a positive antibody response to LAM antigen (Mean:1.11 ± 0.44; sensitivity :63%) specificity of the assay was 95% in normal controls (Mean:0.56 ± 0.17) sensitivity of the test in smear positive-culture positive, smear negative-culture positive and smear negative-culture negative tuberculosis patients was 61%, 67% and 52% respectively.

However, 46.6% of contacts (Mean:0.86 ± 0.28) and 32% of patients with NTs (Mean:0.82 ± 0.27) were also positive by this assay. Sensitivity of the assay dropped to 42.4% with a specificity of 91.3% when healthy controls and NTs were combined together. The test failed to discriminate patients with smear negative and radiologically minimal disease (Mean :0.87 ± 0.34) from contacts and NTs. The positive predictive value of the test was 87.7% and the negative predictive value was 82.9%.

Conclusion

The high rate of false positivity among contacts and NTs and the low sensitivity in tuberculosis patients observed with LAM-ELISA suggest that LAM is not a suitable candidate for the serological diagnosis of pulmonary tuberculosis.

PROBLEMS ENCOUNTERED IN WORKING WITH SEROPOSITIVE PREGNANT MOTHERS

Mary Sushi K, Parameshwari S, Mini Jacob, Anandakannan K, Samuel NM

The Department of Experimental Medicine is involved in Antenatal testing, counselling and creating awareness among pregnant mothers. Interventional strategies of administration of AZT to positive pregnant women and infants to reduce the transmission is an ongoing research programme in the Department. The various issues encountered by the research team will be presented. Problems encountered are in testing antenatal mothers; counselling those mothers who are seropositive, the complicated issues in delivery, follow up and breast feeding will be discussed. The socio-psychological status of positive women and mothers and the agony of positive antenatal women and their problems encountered in dealing these women calls for a change in the attitude of the serving doctors, NGOs and health care personnel. This will be discussed.

PATHOPHYSIOLOGY AND CLINICAL MANAGEMENT OF NUTRITION ALTERATIONS IN HIV DISEASE

Subhasree Raghavan

Definitions and Types of Malnutrition

Macro and Micro nutrient deficiencies are common complications of HIV infection and plays a significant and independent role in its morbidity and mortality 30,31,27,12. Macro-nutrient status reflects the total mass of the body, while micro-nutrient status reflects the efficiency of the body's cellular functions 1.

Macro-Nutrient Malnutrition

Weight loss was one of the earliest complications of AIDS to be recognized and has been one of the most common initial AIDS-defining diagnoses to be reported 1.Weight loss predicts shortened survival, and is associated with higher risks of requiring hospitalization and being diagnosed with opportunistic infections [11]. Weight loss can be episodic and related to an acute

opportunistic infection or progressive in case of chronic gastrointestinal dysfunction 35,

Protein depletion is one of the unique characteristic of AIDS associated weight loss, Evidence of protein deficiency was documented by demonstrating deficiencies in serum proteins, hemoglobin, and by muscle wasting 6. Kotler in his earlier studies, among clinically ill AIDS patients reported disproportionate loss of muscle mass compared to healthy controls, which was associated With shorter survival. However in these patients body fat content was not severely depressed. Women had equivalent depletion of body cell mass as men. but were much more depleted of fat 30. Many later studies conducted in developed and developing world confirmed that wasting occurs differently in men and women with greater depletion of fat in women and muscle mass in men 36,33,44. More recent studiesafter the introduction of effective treatments and prophylaxis against opportunistic infections have shown greater loss of fat in both men and women than early studies and lesser depletion of muscle mass Presence of co-infections such as - tubercuiosi.s and opportunistic infections, and behavioral problems such as substance use are independently associated with weight loss and when co-exist with HIV, they have shown to result in accelerated loss of weight, muscle and fat 38

HIV associated wasting syndrome can arise from two processes: starvation and Cachexia which need not be mutually exciclusive. Starvation is defined as deprivation of food, either voluntary" or involuntary, that leads to weight loss Malabsorption can be viewed as starvation associated with the additonal depletion of electrolytes and water. The effects of starvation can be reversed by providing food or by correcting malabsorption. Cachexia is characterized by a disproportionate loss of lead body mass which results from specific alterations in intermediary metabolism. Feeding alone is not sufficient to reverse the effects of cachexia1. Intervention with anabolic therapies, and more recently use of anti-retroviral therapies have shown to prevent and replete cachexia related loss of muscle.

Micro-Nutrient Deficiencies

Varying degrees of vitamin and mineral deficiencies including B12, B6. ZINC-Selenium. A. E, Magnesium have been reported by several investigators, even when dietary intake exceeded RDAs 7-14. Lower levels of B 12. Selerium, Zinc in HIV infected individuals were independently associated with shorter survival, cognitive dysfunction, enhanced oxidative stress, and muscle weakness.

ROLES OF NGOs & COMMUNITY TO FORMULATE REALISTIC STRATEGIES TO PREVENT A CRISIS IN THE NEXT CENTURY

Gilada IS

Issue

Transmission being mainly linked unsafe sex, equated to illicit sex in the Comemporary society, PLWHAS doesn't attract empathy or sympathy from the society at large. General response from all the corners is categorised into four reactions: Denial, Blaming Others, Reconition & Planning and Despair. India spent over a decade in the first two phases, now entering the crucial third one. Most offical programmes are shrouded with apathy, lack of vision and sense of urgency and are often donor-driven and entirely donor dependent. The National AIDS Control Organisation (NACO) was established only after the World Bank pledged 84.5 million US$ in1992. Underutilisation of budget and poor programming lead it to extension by two years, to 1999. With the next round of 200 million US$ loan by the Bank. the NACO has plunged into second phase. However without a larger NGO and Community mobilization nothing much will be achieved. NGOs have to be watchdog agencies; which makes them vulnerable to be black-listed

Methods

NGOs and communities will have to formulate multi-pronged, realistic, low- cost and sustainable, pro-people strategics to stem the impact of HIV AIDS. NGOs are classified as Commercial Profit Making NGOs, Statutory bodies and Voluntary Non-profit NGOs, however their roles arc not well defined according to their expertise Analysis of AIDS NGOs in Mumbai is revealing. At the meetings with Donor agencies there are over 100 NGOs; at meetings and programmes for World AIDS Day there are 40 visible NGOs; while in intervention with marginalised communities there are hardly ten. The District and State AIDS Control societies show that in past years they have funded over 400 NGOs most of which are the like of Yuva Mandal,. Krida Mandals and Ganesh Mandals. Despite their crticial role in education-awareness programmes their expertise is limited for intervention work. On the contray NGOs of substance are denied

support. Despite this. the committed NGOs continue their tirade come-what-may! NGOs have to exploit their capabilities in advocacy: utilizing media optimally : addressing issues related to human rights violation and discrimination: extending health care and support for PWA: targeted intervention for marginalised groups: networking and training.

Results

Identified community leaders and enterprising NGOs for sensitization to effectively utilize them in prevention, control and management of HIV/AIDS. Several NGOs in areas like peer-education, legal ethical issues, healthcare, community' mobilisation etc. have been borne out of PHO (IHO) initiatives. However after the donor-driven agenda came most XGOs became polarised around donors, in a quest to safeguarding their own interests rather than that of the communities at stake and weakening the network. Highest achievement was getting AIDS on political agenda.

Conclusion

Looking at the projections of HIV and its medico-socio-economic impact, a national effort in ture-sense is required to mobilise NGOs and Communities to free India from the vicious circuit oi Donor -Dependence, Donor-fatigue and Donor-withdrawal that may push into despair. Experiences from Africa and elsewhere should become lessons for us. Integrating sex and HIV AIDS education into curriculum, treating it a national emergency, running cost-efficient, time-tested strategies and making an equivocal response in urban and rural areas is crucial.

PROVIDING SERVICES IN MEGACITIES

Gilada IS

Background

HIV continues to hit India 'below the belt', grossly affecting the people hit by migration and displacement, among other vulnerable communities. Mumbai is worst nit by HIV AIDS, being possibly the entry-point for HIV AIDS and then turning into 'epicentre': harbouring several categories of migrants, most of which belong to marginalised communities The requisite attention and healthcare resource allocation for them is abysmally poor. The vulnerability of the megacities to HIV AIDS is linked to parameters like Prostitution areas, Business Industries, University Colleges, Tourism. Military Base, Roads, Railways, Airpot Port.

Methods

Both vertical and integrated services with their merits and demerit contribute their bit. PHO (IHO) is India's first NGO to have raised an alarm against AIDS in 1985 find subsequently transgressed into a frotline crusader, dealing with A to Z in Prevention. Control and Management of HIV/AIDS. It is known for innovative, low cost- high output approaches from street-corner meetings to World Congress on AIDS, healthcare and support services for PLWHAs; targeted intervention; NGO networking and training. Wider sustainable base was created through sheer hard work against all odd,. with a small resource base, with sense of urgency. Marginalised groups are brought in the mainstream. A comprehensive HIV Care clinic replicating KIS in Germany has been in place tor Five years. With the objective of caring for patients commensurate to their stage of progression, economic condition, family background, living conditions etc. we have drawn up management plans to suit their interests, needs and affordability Patients are provided counseling, clinical examinations, laboratory and radiology investigations, day-care cost-effectively under one roof. Home care is encouraged and patients' visits to medicare facilities are strategically reduced.

Results

Though Mumbai with 250,000 infections and highest reported HIV/AIDS cases has been termed the AIDS capital of India, yet over a

decade long efforts could turn it to an advantageous position of being the AIDS Control, AIDS Awareness and AIDS Care capital of India. Migration enhances health problems of people due to ignorance, lack of access to healthcare, poverty, making them vulnerable to acquire diseases linked to overcrowding, unsafe water, unsate sex. Language barrier, non-conducive atmosphere and lack of family care gels them into cultural shock. High living cost restricts their health-spending paring a way for low-cost comprehensive programmes.

Conclusion

It is high time that services are maintained in the megacities, prioritising migrants, creating health awareness and treatment seeking behaviour. Social security, Health insurance on lines of Employees State Insurance Scheme (ESIS) and assigning responsibility of medico-socio-economic welfare are essential steps to be taken. The Pediatric care should also be tuned to cover Child labourers. Mobile health care services should be provided at vulnerable spots. Whether PLWHAs can afford or not, its our duty to provide them with the effective management for common Opportunistic Infections. Though most are still in early phase of HIV disease spectrum, the future scenario appears grim as most of them can not afford HAART or ART. Cost-effective, comprehensive and quality centre for HIV care should be started in megacities, sooner than later. 2nd International Conference on AIDS in India 2000: Chennai: Dcer6-8.1999.

PSYCHO-SOCIAL PROBLEMS OF THE YOUTH, IN THE CONTEXT OF HIV INFECTION

Jacob John T

In spite of being the first country in the world to establish a national semiquantitative serological investigation of HIV transmission (1986), India failed to design effective measures of control. It is now very clear that our youth are vulnerable and at high risk to get HIV infection. Unless we understand the psycho-social issues of early sexual experience we will not be able to address any potential remedial meausres.

Early pregnancy (below 20-21 yrs) is associated with increased risk to life to both the foetus/neonate and the mother. While early sexual

experience may do no physiological harm, its effect on subsequent soci and sexual behaviour does not seen to have been studied in India. When culutural, religious, family and social teachings/expectations are again pre-marital sexual experience, a proportion of adolescents/yourth seem to behave contrary to this norm. Since, 'safe' sex practices are not usual at this stage, the consequences certainly include, in this day and age, the risk of (and actual) infection with HIV. What are the influences and circumstances which promote early sexual experience?

We interviewed 208 consecutive, healthy, HIV infected persons who were attending our counselling service. Among them 14.5% were youth (<25yrs) and 77.4% were young adults (25-39 yrs); 119 were married and 89 were single. They reported first sexual experience at (mean) age of 18 years (range 13-27). Their source of 'knowledge' about us was from movies (not explicit, but implicit), ponographic movies, magaz and books and peers.

Going out for sex after feeling aroused by movies, especially, their teens, was reported by 68% ; whole day outings/pienies combined with sex was reported by 66%. Habits of smoking and/or drinking alcohol were reported by 80%. During their entire sex-life 76% had never used condoms and the rest had used it only occasionally. There was suggestive evidence that early family relationships in childhood had a bearing on their behaviour which they knew was contrary to expectation.

Easy access to sex workers or other sex parterns, "peer pressure alchol, movies, etc. are influences that seem to promote early and importected sex experiences in this study population, which have presumably resulted in HIV infection.

We urgently need studies into the prsycho-social influences in children and adolescents which determine them from, or promote, early and unsafe sexual experiences. Without understanding such influeces we may not be able to develop suitable approaches to enable yougsters to understand choice-making when confronted with opportunities to experiment with various forms of addition -be it smoking, alcohol or sex. We need to create opportunities for influences that will protect them from the health hazards of such addiction-forming behaviours.

CURRICULUM VITAE

DR. K. ANANDA KANNAN

Vice -Chancellor
TN. Dr. M.G.R Medical University

Qualification :

Exam passed	Year of acquiring	University
M.B.B.S.	1966	Madras
M.S. (Ophthalmology)	1974	Madras
M.A.M.S.	1977	New Delhi

Former Post & Designation : Director & Superintendent, Regional Institute Ophthalmology,

Government Ophthalmic Hospital, Egmore, Chennai - 600 008.

Prof. & HOD of Ophthalmology, Chennai Medical College, Chennai - 3.

Experience & Position Held : Asst. Surgeon, Tamilnadu Medical Service since 1968-1985

Civil Surgeon, Tamilnadu Medical Service since 1985.

Super Specialisation & Area of Interset : Eye-banking & Corneal Transplantation Medical Director, Lions Model Eye Bank, Regional Institute of Ophthalmology & Ophthalmic Hospital, Chennai - 8.

Conferences Attended, Participation and Papers Presented : All India Ophthalmic Conference held in Conference held in various parts of the country since 1974 20 Papers.

State and Southern Regional Ophthalmic Conferences held since 1973. 40 Papers presented.

AERO Asian Conference, International I.O.L. Conference and ASIO-PACIFIC Conference held in 1976, 1983, 1985 at Madras, Bombay and Delhi respectively.

III Assembly on I.A.P.B. at Delhi 1986. International Ophthalmic Conference at Singapore 1991.American Academy Meeting at San Francisco 1994.

American Academy Meeting at Chicago 1996

Overseas Observership : a) Massachussets Eye and Ear Infirmary, Boston - 1994&96

b) Georgetown University Hospital, Washington 1994

c) Gensee Valley Eye Care, Rochester, New York, 1994

d) Brown University, Rhode Island, 1996

Present Position : Vice-Chancellor
TN DR MGR Medical University and
President of this Conference.

DR. MARK A.WAINBERG

He is an internationally recognized scientist in the field of HIV/AIDS, who has made important independent contributions both to the study of virus host interactions and, more importantly, to anti-viral drug development. Professor Wainberg was the first scientist in Canada, beginning in 1984, to work directly to HIV and to isolate the virus from patient populations. His research has helped to define conditions that govern differential infection by HIV of lymphocytic versus monocytic cell populations, and he has also characterized sub-populations of T helper lymphocytes, notably CD4 and CD8 cells, in HIV infection. His work has also dealt with the nature of anti-viral immune responsiveness in individuals infected by HIV. Dr.Wainberg's laboratory was among the first to characterize the phenomenon of HIV escape, through mutagenesis, from immunological pressure.

Dr. Wainberg is recognized internationally for his research in the area of HIV drug development and drug resistance. He is well known for his initial identification of 3TC as an anti-viral drug, in collaboration with BioChem Pharma Inc. in 1989, and has contributed numerous papers to the international literature on drug action and drug resistance in AIDS. 3TC is today recognized as the most widely used drug in the world in the treatment of HIV disease, and over time, may be recognized as Canada's most important drug contribution since the discovery of insulin approximately 75 year ago.

Following Dr. Wainberg's research in this area, other Canadian investigators contributed to the discovery that 3TC can also block the replication of hepatitus B virus. Thus, this Canadian developed drug may prove to be effective against two distinct viral diseases. His laboratory continues to work in the area of new drug discovery and, as well, Dr. Wainberg has now turned his attention to novel concepts in HIV vaccine development and prevention of HIV infection. Together with Biochem Pharma research in Dr.Wainberg's lab has also identified a second anti-HIV compound, dOTC, that is now in clinical trials and that shows great promise.

The role that he has played in HIV/AIDS has been recognized by his election as President of the International AIDS Society for the period 1998-2000. Dr. Wainberg is using his Presidency to advocate for measures that will enhance prevention of HIV infection in developing countries. He was Co-Chair of the Second International Conference on Prevention of Mother-to-Child Transmission of HIV, that took place in Montreal in September, 1999 and will be Co-Chair of an International Conference of HIV Microbicides, planned for Washington in March 2000. He has also led a successful application to bring the International Conference on AIDS, the largest medical conference in the world. Back to Canada, Dr. Wainberg will be the Chair of the XV International AIDS Conference, that will take place in Toronto during the summer of 2004.

In a survey of publications on the basic science aspects of HIV/AIDS in highly ranked journals for 1995-97, carried out for the XII International Conference on AID, Dr. Wainberg was ranked 12th in the world and was the only Canadian on a list of the top 50 cited authors. In addition, Dr. Wainberg has been a member of numerous scientific and review committees in Canada, the U.S. and abroad and is a frequent speaker at scientific meetings throughout the world.

DR. SANKARAN JR

- Emeritus Professor of TN. Dr. MGR Medical University, Chennai.
- Formerly Professor of Medicine, Madras Medical College & Physician, Govt. General Hospital, Chennai.
- Formerly WHO/National Consultant on AIDS, Southern Region.
- First Professor of Medicine in the Country to undergo training in AIDS, as WHO fellow, in USA.
- Participated in several national and international conferences on AIDS.
- Has Several Publications on HIV Medicine in journals and books.
- Recipient of Dr. BC Roy Award for Eminent Medical Teachers.
- Recipient of Gifted Teacher Award of API.
- Chairman, Scientific working Committee of this Conference.

LARS O. KALLINGS

Born in Stockholm, Sweden in 1930. MD and PhD at the Karolinska Institute in 1957 and in 1961 resp. Professor in medical microbiology in 1963. Director General of the Natl. Bacteriological Laboratory (Natl. Institute for Control of Infectious Diseases and Production of Vaccines) in Stockholm 1982-1988. Vice President WHO Executive Board and Chairman WHO Global Commission on AIDS 1998-1990. Scientific adviser to the Swedish Government 1988-1994. Founding President International AIDS Society (IAS) 1988-1990. Senior Adviser on Scientific and Policy Affairs to the Global Program on AIDS, WHO, Geneva 1990-1993. Secretary-General of IAS since 1994, based in Stockholm, Sweden.

PETER MUGYENYI

Degree(s)

Bachelor of Medicine and Surgery (M.B. Ch.B) Makerere University, Kampala, Uganda. 1975

Child Health (D.C.H.R.C.P.S), Glasgow, UK. 1981

Medicine (M.R.C.P), UK. 1983

3. Posts held

- Director, Joint Clinical Research Center, 1992 to date
- Deputy Chairman: Mbarara University of Science and Technology (MUST) 1993 to date
- Secretary: UNAIDS HIV Drugs access initiative. 1998 to date
- Consultant Pediatric Physician and Hon. Senior Lecturer, Makerere University Medical School. 1989-1992
- UNDP Consultant Makerere University Medical School, and Mulago Hospital Department of Pediatric and Child Health. 1989-1992
- Consultant Pediatrician, Maternity and Childrens Hospital Jeddah Saudi Arabia. 1984-1985
- Head of Department of Pediatrics and Director of Research and Postgraduate training at the Maternity and Children's Hospital Jeddah Saudi Arabia. 1986-1989.

DR. N.M. SAMUEL

After medical studies in Christian Medical College, Vellore , Dr. N.M. Samuel worked in Bhutan for three years. He went on to obtain his M.Sc. in clinical tropical medicine from London School of Hygiene & Tropical Medicine,followed by his Ph.D from Middlesex Hospital Medical School,London . He joined the Tamil Nadu Dr.MGR Medical University in the year 1991 and started the Department of Experimental Medicine/SMIC from scratch. In 1993 he was appointed as the Professor. The department's focus is on HIV/ AIDS, TB and Leptospirosis. Current priorities include antiretroviral drug studies in women/children and pregnant women and infants. HIV subtype studies are underway. He has published 62 scientific papers. He is a member of the UNAIDS virus network, Geneva and serves on the Task force on Medical Biotechnology in Department of Biotechnology.

DR. STEFANO VELLA, MD

Stefano Vella, MD, is Research Director at the Laboratory of Virology of the Italian National Institute of health and Chair of the Italian Clinical Research Program on HIV/AIDS

Working and Research Experience:

1981 to 1991 - Clinical and Research Assistant, Institute of Internal Medicine, University of Rome

1981 to 1982 - Associate Scientist, University of Pennsylvania, USA.

1992 - Research Director, Laboratory of Virology, Istituto Superiore di Sanita

1993 - Head, Retrovirus Section

1993 - Head, National HIV Clinical Trial centre.

1996 - Chair, Italian national Research Project on Clinical Aspects and Therapy of HIV infection

Memberships and Appointments:

- Italian National AIDS Committee (Italian Ministry of Health) (since 1991)
- Working Group on Treatment of HIV Disease, Council of Europe, Strasbourg (1991)
- NIH Panel to define principles of Therapy of HIV infection (1996)
- Ad- Hoc Working Group on Antiretroviral Medicinal Products-(EMEA)-London (since1996)
- Review Committee on HIV Research Projects, NIAID, NIH,USA (1995)
- Swiss Federal Office of public health, review of the swiss HIV Cohort Research Projects (1996-1998)
- Editoroal Board, " AIDS (since 1996)
- Editorial Board " Antiviral Therapy" (since 1996)
- Associate Editor, AIDS Clinical care (Massachusetts Medical Society) (since1995)
- Member, Governing Council, international AIDS Society (IAS) (elected,1996)
- President-Elect, international AIDS Society (IAS) (elected,1998/on duty, 2000)

Dr. Vella has been invited speaker at plenary sessions in over 60 International Conferences, including the X11 World AIDS Conference (Geneva,1998) and the V1 Retrovirus Conference (Chicago,1999).

DR.MARK MIROCHNICK, M.D.

Division of Newborn Medicine, Boston
Medical Center Place Boston, MA 02118 Phone: (617) 414-5461
Fax: (617) 414-7297
E mail: mark.m@bu.edu

Education college : Dickinson College, Carlisle, PA
Bachelor of Sciences, Summa Cum Laude,
Phi Beta Kappa, June 1975

Medical School : University of Vermont College of Medicine,
Burlington, VT, Doctor of Medicine, June 1980.

Internship : Pediatrics, Boston

Postgraduate Training :

1980-81 : City Hospital (now Boston Medical Center), Boston, MA

Residency : Pediatrics, Boston City Hospital (now 1981-83 Boston Medical Center), Boston, MA

Fellowship : Neonatal-Perinatal Medicine, University of 1984-86 Connecticut Health Center, Farmington, CT

Employment:

1983-84 Affiliate Staff, St. Margaret's Hospital for Women ane Carney Hospital, Boston, MA

1986-1996 Assistant Professor of Pediatrics, Boston 1986-1997 University School of Medicine, Boston, MA

1986-present Associate Neonatologist, Boston City Hospital/Boston Medical Center, Boston, MA

1996-present Associate Professor of Pediatrics, Boston University school of medicine, Boston, MA

Board Certification :

1985 Pediatrics #32557, 1987 Neonatology #1800

Dr. Mark Mirochnick has many publications in International journals to his credit. He has authored many chapters in several books.

DR.R.P. BERNARD

Dr. Bernard has founded in 1988: AIDS FEEDBACK {AF}- an academic action effort to diffuse worldwide latest knowledge on AIDS and HIV incidence and prevalence with the aim of sensitizing decision makers for more provision in information and PREVENTION programmation. A systematic GLOBAL ANALYTICAL INTEGRATION {GLANIN}and worldwide spread has led to method development and new observations. Dr. Bernard has his MD and doctorate degree from the university of Geneva {1957&1959}, his city of birth .He trained in Paris {Pasteur Institute /Sorbonne}and was an CNRS/NIH research fellow at the institute Pasteur from 1959&1964. His official 'Pasteur -Swiss Government /SNSF' report on the 1963 Zermatt Typhoid Epidemic in 1965 earned him a Senior fellowship at the University of Washington, Seattle, where he obtained his MSPM in 1967 [with an inquiry into smoking behaviour among UW freshmen]. As first research director of the Harvard - affilited Pathfinder Fund [Cl.Gamble] from1967-1971, he developed the INTERNATIONAL IUD PROGRAMME {E.Kessel }to test many means of fertility control{1972-1984 },which in turn developed into FAMILY HEALTH INTERNATIONAL. The IFRP developed MATERNITY CARE MONITORING {MCM }which was then adopted by FIGO as a world tool of study {H.D. Watteville,etc}. Over 1 million births were studied by south -colleagues and reported in prestigious north- journals. On specific suggestion by a US group of epidemiologists, he shifted in 1987 to the endpoint AIDS and then HIV proper. AIDS FEEDBACK [AF] has generated over 30 analyses and modular documents that are today a chain of references. His work continues to be supported by the Swiss Federal Office of Public Health via the institute for Social and Preventive Medicine of the university of Zurich .

DR. URUSULA DIETRICH

Present position :		group leader of Molecular Virology
Title	:	laboratory director (stall scientist)
Institution	:	GeorgSpeyerHaus, Frankfurt, Germany
Education	:	
1959-1972		Primary and secondary school at the (Jerman School in Madrid (Spain)
1972		Immatriculation at the University of Freiburg, Germany, for Biology
1975		B.S., Biology, Chemistry, Mathematics
1979		Diploma in Molecular Biology. Cellular Biology. Biochemistry
1983		Ph.D in Developmental Genetics at the University of Freiburg

Research Experience:

1979-1983	Graduate student at the University of Freiburg, Germany developmental genetics, genetics, histology
1983-1987	Postdoctoral fellow at the University' of Cologne. Germany developmental genetics, molecular biology fellowship from the Boehringeringelheim foundation
1987-1989	Postdoctoral fellow at the GeorgSpeyerHaus in Frankfurt. Germany, molecular virology of HIV
Since 1989-today	Group leader of Molecular Virology at the Georg-Speyer Haus
1994-1997	also project leader of the European Centralized Facility for HIV Genome Analysis (BIOMED 2)
Until today	Molecular epidemiology of HIV subtypes, resistance determinations, neutralization of HIV, phage display techniques for identification of new antiviral targets
Memberships	International AIDS Society (IAS), Society for Biochemistry and Molecular Biology (GBM), Society of German Scientists and Physicians (GDNA)
Editor	Journal of "AIDS Reviews"

DR.L. CECILIO LOPEZ GALINDEZ

Professional address : Centro Nacional de Biologia Fundamental institute de Salud "Carlos111" Majadahonda Madrid 28220 SPAIN

Degrees :

1976: Bachelor in Sciences, Biochemistry, Uninersidad Complutense de Madrid.

1983 : Ph. D. "Molecular Epidemiology of Influenza" Supervisor - Dr. R. Najera. Universidad complutense de Madrid.

Career and employment :

1981-84: Centro de Biologia Molecular. Universidad Autonoma de Madrid in the laboratory of Dr. E Domingo and Dr. J. Ortin.

1986-87: Department of Biochemistry of the State University of New-York at Stony Brook in the laboratory of M. Perucho.

1988-90: California institute of Biological Research, La Jolla. Laboratory of M. Perucho.

1976-83: Faculty in the Department of Virology, Centro Nacional de Microbiologia Virologia e immunologia Sanitaria.

1983-88: Faculty in the Department of Molecular Biology Centro Nacional de Microbiologia Virologia Inmunologia Sanitaria.

1988-90: Faculty Centro Nacional de Biologia Fundamental.

1990 : Head Molecular Virology Unit. Centro Nacional de Biologia Fundamental institute Carlos.

Several publications in leading journals.

KADAR MOHIDEEN ALLAUDIN

He belongs to 1981 batch of Indian Administrative Service. He has worked extensively in the field in various capacity as Sub Collector. Project Director for District Rural Development Agency, District Collector and Commissioner and Chief Executive of Madurai and Madras (now Chennai) Municipal Corporations. He has taken keen interest in social sector including the Health. He implemented the IPP V Project in Chennai City and initiated HIV /AIDS awareness work in the City in 1992-93 itself He has attended several International Conferences.

He is presently serving as Special Secretary in the Ministry of Health and Family Welfare, Govt. of Tamil Nadu since May 1996. He is also the Project Director and Member Secretary of Tamil Nadu State AIDS Control Society from December 97 in which capacity he is actively involved in implementing HIV/AIDS prevention and control activities in Tamil Nadu.

He participated in the Pre-project appraisal consultations with the World Bank at Washington D.C. in November 98 as part of delegation from Government of India. He served as a resource person for the preparation of Project Implementation Plan for source of the States under NaCP.2.

DR. KOZLOV ANDREI PETROVICH

Educational History :

M.S.,1972, Chair of Biochemistry, Leningrad University, Leningrad, Russia

Field of study -Biochemistry

Ph.D., 1975 Laboratory of Biochemistry , Institute of Oncology, Leningrad, USSR

Field of study -Biochemistry

Doctoral thesis :

"Comparative Study of Small Nuclear RNAs in Normol and Malignant Tissues"

Postdoctoral Research Training:

1975-78 Lab of Biochemistry , Institute of Oncology, Leningrad, USSR

1978-79, Robert gallo, M.D., Lab of tumor Cell Biology,Naional Cancer Institute , National institutes of Health,

Bethesda, MD USA; Visiting Fellow; Molcular virology.

Current And Previous Institutional Affiliations:

1998-Date Professor, St. Petersburg University ,St. Petersburg , Russia

1997-Date Coordinator, Russian HIV vaccine project

1997-Date Founder and Editor -in-Chief " Russian Journal of HIV/AIDS and Related Problems"

1994-Date Executive Director, Association against HIV/AIDS

1991-Date Director ,Biomedical Center , St. Petersburg , Russia

1998-Date Chief Lab of Molecular Virology, Research Institute of Pure Biochemicals , St. Peterspurg , Russia

1980-1988 Senior Investigator, Lab of Genetic Engineering , Research Institute of Pure Bio-chemicals Leningard, USSR

1979-1980 Staff Member , Lab of Biochemistry , Institute of Oncology,Leningard, USRR

Area of Expertise:

Molecular virology , Molecular Epidemiology , HIV/AIDS research.

D.G. SAPLE

Professor D.G. Saple is attached to The Department of Skin, STD's and Leprosy, G.T. Hospital, Grant -Medical College, Mumbai as Hon. Associate Professor. He is working in the field of Epidemology & Management of HIV-AIDS for last 13 years. The G.T.Hospital Skin Department is one of the largest departments in Asia and the fist to detect HIV-II in Asia. The daily OPD attendance is About 50 to 60 while the indoor admission is30-40 HIV -AIDS patients at a given time.

He is the founder member of SPA (Society for prevention of HIV-AIDS).He is the council member of College of Physicians & Surgeons. He is also an Executive member of Association of Hon. Medical Officers. Grant Medical College. Member of Medical Advisory Panei of Family Planning Association of India (FPAI) He is an advisor to the Government of Maharashtra for the control of HIV-AIDS. Prof. Sample is an ex-member of NACO -National AIDS Control Organisation He is the ex-President of Indian Association of Dermatology Venereology and Leprology (MH branch).

He is the main author of Chapter on HIV -AIDS in IADVL'S "Textbook and Atlas of Dermatology He has presented papers on various topics of HIV-AIDS at several National & International Conferences Latest interest -HEART (Highly Effective Anti Retroviral Therapy).

DR.ATUL K. PATEL MD

Education

MD (Gen. Medicine), BJ Medical College, Gujarat University, Ahmedabad, India, March '92 (University Second-Rank,) MBBS, BJ Medical College, Gujarat University, Ahmedabad, India, 1987.

Work Experience

Practicing HIV and Infectious Diseases Consultant since November, 94 Hon. Assistant Professor in Medicine, NHL Municipal Medical College & KM School of Post Graduate medical studies & research. Ahmedabad, India, February. '94 - Present Full time Assistant Professor in Medicine, BJ Medical Collage & Civil Hospital. Ahmedabad. November '92 - January '94 Residency in General Medicine and Subspecialties, New Civil Hospital, Ahmedabad, India, Sept '87-Nov'92

- Hon. Assistant Professor Medicine, NHL Municipal Medical College & KM School of PostGraduate medical studies & research. Ahmedabad,India, February. '94 - Present
- Full time Assistant Professor in Medicine, NHL Municipal Medical College & research. Ahmedabad, India, February .'94 - present
- KM School of Post-Graduate medical studies & research. Ahmedabad, India, February'94
- Full time Assistant Professor in Medcicine, BJ Medical Collage & Civil Hospital Ahmedabad. Novermber'92 - January '94

Areas of Special Interest

HIV & opportunistic Infections
Hospital Acquired Infections
PUO (Pyrexia of Unknown origin)
Infections in lrnmunocompromise Host

Licensure

Gujarat Medical Council, Ahmedabad - Registration # G-17728

Publications

HIV - Primary care approach & Management . Gujarat Medical Journal -July 97, page 3-9

B-19 Parvorius infections as cause of severe anemia in an HIV Infected Patients, case reports. Indian Journal of Hematology and Blood Transfusion, Vol.26, No. I, March 1998, page: 38

Involved in several research projects, as a principal investigator.

Areas of Experience

Consulting approximately 16-25 new patients per week with various HIV related illness in outpatient clinic at my consulting room.

- Actively involved in the managment of patients admitted with PUO, Hospital acquired pneumonias, other infections. Also attended to referrals for expert opinion from other departments.

DR. O.C. ABRAHAM

Department of Medicine-Unit,
Christian Medical College Hospital,
Vellore 632 004, Tamilnadu, INDIA.

Educational Qualifications :

M.B.B.S.

M.D.(Internal Medicine)

M.P.H.

Education Qualifications:

Year & University

Pre-Medical 1974-1976 University of Kerala

Medical-M.B.B.S. 1976-1981 Government Medical College, Kottayam
University of Kerala

M.D. (Internal Medicine) 1986-1989 Christian Medical College, Vellore
University of Madras.

M.P.H. 1993-1994 University of North Carolina at Chapet Hill.

Chapet Hill, North Carolina.

Fellowship in Infectious

Diseases 1996-1998

Wayne State University School of Medicine.

Detroit, Michigan.

He has Published in National & International Journals.

DR. MANJULA DATTA

Professor and HOD
Department of Epidemioogy
The Tamil Nadu Dr. M.G.R.Medical University,
Guindy, Chennai - 32.
Manjulad@yahoo.com

Educational Qualification : M.D. ,D.C.H.,M.Sc.,

Research Experience : 25Years in the field of Tuberculosis

Major Achievements

- First person to be trained in clinical epidemiology in our country.
- Established the advanced centre for clinical epidemiology research and training (ASSERT).
- Developed a draft curriculum for M.Sc., in epidemiology for funding by the WHO-UNDP Special Programme on Tropical Disease.
- Reorganised the B.C.G. trail infrastructure in department of epidemiology at the Tuberculosis Research Centre, Chennai.
- Involved a long term project on HIV infection and TB.

Present Research Interest

Childhood Tuberculosis and other respiratory infections. Vaccine preventable diseases and Immunization, Chronic disease like diabetes and hypertension etc.

Present Position : Prof.&HOD
Department of Epidemiology
The Tamil Nadu Dr.M.G.R.Medical University.

DR. JAISING MARUTRAO PHADTARE
MBBS, MD, FCCP.

WORK EXPERIENCE

Presently Hon. Professor of Chest Diseases, Grant Medical College, Bombay. He has teaching experience of 20 years after completing his MD degree. He has undergone various training in technical aspects such as,treatment and reservation of acute cardiac emergencies and acute trauma victims and flexible fiberoptic bronchoscopy & laser application.

PROF. SHOBHA SEHGAL

Obtained her MBBS degree from Medical College, Amritsar in 1960 and studied Pathology at the Postgraduate Institute of Medical Education & Research, Chandigarh (PGIMER) and received MD Pathology in 1967 with honours. She worked in different capacities in the departments of Pathology for over 30 years and rose to become the Head of the Department of Immunopathology in 1978 and Professor of Immunopathology in 1984. Currently she is also the Chairperson of Department of Pathology. She has participated in various Indo - US and Indo- UK collaborative projects notably, Leishmaniasis and Immuno contraception. She has been the past President of the Indian Immunology society, has served as an advisory member of several national bodies and as a member of the task force of the WHO, Geneva on Immuno contraception for five years. She has been running an AIDS Surveillance Centre at the PGIMER since 1987. She has more than 225 papers to her credit including 12 charters in books and over 20 publications relating to AIDS. Her current interests are co infections in HIV/ AIDS and HIV sub- types in Punjab.

DR. JYOTIRMAY BISWAS

Dr. Jyotirmay Biswas was born on 8.10.1954 is one of a rare breed of clinicians who has specialized in both clinical and basic sciences. After postgraduation in Ophthalmology from Postgraduate Institute of Ophthalmology, Chandigarh and a fellowship in vitreoretinal surgery at Sankara Nethralaya. He probed into the pathogenesis of ocular diseases particularly prevalent in India. Ophthalmic pathology, which has emerged as a distinct subspeciality in recent years. Dr Biswas took up this new branch as his area of specialization.

Since 1985, he started working on pathobiology of many ophthalmic diseases, especially Eales' disease. Dr Biswas received a prestigious 2 years fellowship in ophthalmic pathology in 1987 at Doheny Eye Institute. University of Southern California, USA. Subsequently, he received travel fellowship by Association of Research in Vision Ophthalmology (ARVO), the leading international eye research body. He subsequently made several presentations at the annual meeting of ARVO and 2 presentations at the prestigious Hogan Society of Ophthalmic Pathology in USA.

Dr Biswas has published 70 articles in peerreviewed National and International journals , 4 chapters in two books in USA and 20 chapters in various ophthalmology & pathology books in the counts. He is a member of International Uveitis Study Group.

Dr J Biswas has published 8 articles in various National and International Journal of Ophthalmology on AIDS including report of first two cases of ocular lesion in AIDS. Recently, his article on Ocular lesions in 100 HIV positive patients has been accepted for the publication in prestigious Americal Journal of Ophthalmology.

DR J Biswas has received 10 awards which include travel fellowship from Association for Research Invision and Ophthalmology USA and Hari Om Ashram Alemoic Research Award by Medical Council of India for Clinical Research for the year 1997.

DR. SANJAY PUJARI

Education:

B.J .Medical College and Sassoon General Hospitals Pune, India. M.D. (Internal Medicine), 1995

Research Paper presentations at Pujari S, Walimbe P, Patwardhan N, et.al. Impact of education on knowledge regarding AIDS amongst rural students in Maharashtra, India, Int Conf AIDS (1992) S(2):D406 (abstract no. PoD 5119)

Pujari S, Oak V, Khatavkar P. et.al Effective AIDS prevention strategy amongst STD patients in Pune. India. Intl Conf AIDS (1993) Pujan S, Oak V. khattavkar P. et.al. Counselling Voluntary blood donors tested HIV positive in India, Int Conf AIDS (1994) 10(2):389 (abstract no. PD0 739) Pujari S, Wadia RS, Grant KB, et.al. Seroprevalence of toxoplasma antibodies amongst HIV infected individuals in Pune. India. Int Conf AIDS (1998) 12:98-9 (abstract no 12426) Pujari S. Gupte N, Wadia R et.al. Total lymphocyte counts as alternative to CD4 counts in resource poor countries Int Conf AIDS (1998) 12:98-9 (abstract no. 12426)

Pujari S, Khatavkar P, Oak V, et.al. Health education about AIDS amongst urban college students. Intl Conf AIDS Asia Pacific (1994) Pujari S, Oak V, Wahi S, et.al. Perceptions about care amongst PHIVs and their families in India. Intl Conf AIDS Asia Pacific (1995) 108 (abstract no. C604) Oak V, Pujari S, Dehadry A, et.al. Clinical and immunological profile of otorhinolaryngeologic manifestations in HIV infection. Intl Conf AIDS Asia Pacific (1995) 108 (abstract no. PA 404) Pujari S, Wani D, Kulkarni H, et. al. Efficacy of DHSI and DHCI - Herbal preparations in HIV infected individuals: A pilot study. Intl Conf AIDS Asia Pacific (1997) 90 (abstract no. C(O)003). Pujari S, Oak V, Khatavkar P. Evaluating the impact of counseling in helping clients and families cope with HIV/AIDS in India. Intl Conf AIDS Asia Pacific (1997) 301 (abstract no.C(P)021). Pujari S, Wadia RS, Bhagat S, et.al. Correlation of CD4 counts with opportunistic infections of in HIV disease. International inference on AIDS India 2000. Chennai 1997 (invited talk).

Editor:

Proceedings of National Conference on HIV Medicine 1990 Research Publications. Pujari S, Khatavkar S, Phadke A, et.al. Heart disease as presenting manifestation of HIV Infection-First report from India CARC Calling 1993:13-17. Seroprevalence of Toxoplasma amongst HIV infected individuals Pune India ARR 1998,1:10-15 12th World AIDS Conference : Clinical Care review -Part I ARR 1998, 1:26-31.

12th World AIDS Conference :Clinical Care review -Part II APR, 1999; 1 Ethics of ARV treatment in India -Guest Editorial Medical Ethics Jan 1998 Neurological manifestations of HIV disease in India (Proceedings of National Medicine Update 1998, AFMC:24-30).

Fugal infections in HIV/AIDS (Proceedings of National Conference of HIV Medicine 1996: 63-71)

Prof. DR. MANIAR JANAK KESHAVLAL

Affiliations:

- Honorary Physician in Dermatology/STD/HIV/AIDS at G.T. Hospital, Grant Medical College, Bombay
- Honorary Professor of Dermatology & STD at Grant Medical College (Attached to University of Bombay), Bombay.

Achievements

- Recipient of Silver Jubilee Oration Award of institute of Venereology, Madras instituted by Indian Association of STD & AIDS.
- Author of a chapter "AIDS in INDIA" in Text book of AIDS by German author DR. HANS JAGER
- Member of Editorial Board-International Journal of STD & AIDS.
- Appointed as Consultant for team organising guidelines for management of Clinical AIDS Medicine for National AIDS Control Organisation, Union Ministry of Health. Govt. of India.
- Appointed by British Deputy High Commission-DPID as National Consultant for Control of STDs & AIDS programme for West Bengal Sexual Health Project.
- Past President of Indian Association of STD & AIDS.
- Have distinction of managing over 32,500 HIV +ve individuals since 1988 (upto May 1999)
- One of the pioneer scientists working in the field of HIV/AIDS medicine in Bombay since 1986. Actively involved in the management of HIV/AIDS patients.
- First Asian Physician to detect Existence of HIV-2 infection in Asia Pacific in December 1990 with German Virology Laboratory collaboration.
- First Asian Physician to detect HIV-1 subtype C with German Virology Laboratory collaboration.
- First Indian Physician to successfully culture HIV-1 & HIV-2 in collaboration with German Virology laboratory.

PROF.S.A.JAYAKAR PAUL M.D

Graduated from the Madras Medical College, Madras, and a Post- Graduate in Medicine from the University of Madras. Held the post of Senior Physician in the Madras Medical Service and retired as the Professor of Medicine and the Head of the Department of Internal Medicine in the Madras Medical College, Madras. Now holding the posts of Emeritus Professor of the TN Dr.MGR Medical University, Madras, Member of the Tamil Nadu Medical Council, Madras, and Consultant in Medicine to the Madras Port Trust Hospital, Madras, and YRG Care Foundation Consortium, Madras. Previously was the President of the Indian Association of Occupational Health, Madras chapter. Trained by the WHO in Australia in the Clinical Managment of HIV/ AIDS, held the position of State Physician for the Management of HIV/ AIDS and Faculty Member of the National Aids Control Organisation and the State AIDS Control Organisation and the Indian Council of Medical Research Committee. Conducted many training programs in the national level in prevention and treatment of HIV/ AIDS infection.

DR . S. PARAMESWARI
Department of Experimental Medicine
The TN Dr.MGR Medical University

Dr.S.Parameswari completed her M.B.B.S from Stanley Medical College and underwent her special trainee in the field of . Obstetric and gynaecology and Paediatrics at RSRM hospital. Joined as Research Medical Officer under ACCERT[ICMR] ICMR at Institute of Child Health. For the past 5 years working as Reser ach Medical Officer at the Department of Experimental Medicine and AIDS Resource Center-TN Dr.MGR Medical University with special interest on mother to child transmission.

Presented papers in many workshops, Conferences. Has been a faculty member in conducting training programmes In the Department of Experimental Medicine. Underwent Training in KIS Hospital in Munich, Germany. Attended and presented papers 12th at the World AIDS Conference Geneva, June 28 -July 3rd 1998 and in the Second Conference on Global Strategies for the prevention of HIV Transmission from Mother toJ^rFa^cs on September 1-6,1999.

Dr. P. KRISHNAMURTHY

Education

- Bachelor Of Medicine and Surgery
- Post Graduation In Public Health
- Post Graduation In Health Education

Present Position : Project Director, APAC -VHS

Specialisation : Health Administration, Research, Monitoring And Evaluation Of Health Projects

Professional Association :

- Indian Public Health. Association
- Indian Society For Health Administration
- International Union Of Health Education
- Indian Society For Communicable Diseases

Experience

- As Public Health Physician Responsible To implement, Organise And Manage Variety Of Public Health Programs Throughout The Stmz On Subjects Of Primary Health Care, Communicable Disease Control, Mch & Fw Training, Operational Research Etc.
- Participated In Conferences And Seminars On HIV\AIDS
- Presented Papers (both Oral And Posters)
- In National And International Conferences .
- Since March 93, Fully Associated With Aids
- Prevention And Control
- Responsible In Formulating Strategies For Communication Of HIV\AIDS Messages
- Participated In A Number Of Surveys And Research Studies On Health And Aids

DR.T. JACOB JOHN

Dr. T. Jacob John, formerly the Professor and Head of the Departments of Clinical Virology and Clinical Microbiology at the Christian Medical College Hospital, Vellore is now the Emeritus Medical Scientist of the Indian Council of Medical Research. He started his career as a paediatrician (DCH, FRCP) and due to the need for laboratory support for specialising in infectious diseases, became a virologist (MSc, PhD) himself. Applying both these skills he addressed public health issues and became known for his expertise in epidemiology. Thus, in 1986 itself, Dr. John showed not only the presence of HIV in India, but also that HIV has spread into the interior of Tamil Nadu and that the main mode of transmission was heterosexual, particularly between male clients and female CSW.

Dr. John is a Fellow of all National Science Academics of India. He was the President of the Indian Association of Medical Microbiologists in 1994 and President Elect of the Indian Academy of Pediatrics in 1998. He is the recipient of the BC Roy Award for the Eminent Medical Person of the Year 1990.

AMANDA MURPHY

Amanda Murphy was born in Belfast in 1962. She studied at the Royal Veterinary College, London and subsequently gained a B.Sc. (Hons) degree in Animal Physiology and Nutrition.

Numerous jobs included Factory Management and Zoo keeping. Came to India in 1989, with no money. After a failed marriage a stubborn high streak prevailed upon her to stay and address the needs of Children in Madurai District to build a school. The only way to make money was to establish a business. Beginning with five people today that company, Teddy Exports, employ over 300 disadvantaged people and dedicates up to 50% of its profits to Aids Awareness, Veterinary core, community health and education in the area.

She was awarded MBE is queens honours list for her work in India.

DR. KOEN A. VAN ROMPAY

Assistant Research Virologist

Education

School of Veterinary Meidicine, State Veterinary Medicine- 1989 , University Center Ghent Belgium, D.V.M.

Ph.D. - 1994, University of California, Davis, CA

Research/professional Experice

1996 present : Assistant Reasearch Virologist at Virology and Immunology Unit,

California Regional Primate Research Center, Davis,California

1994-1996 : PostGraduate Researcher at Virology and Immunology Unit, California Regional Primate Research Center, Davis, California

1989-1994 : Graduate Student/Postgraduate researcher at Virology and Immunology Unit, California Regional Primate Research Center, Davis, California (under spervison of Dr. N.C. Pedersen and Dr. M. Marthas).

Membership

American Society for Microbiology

Awards/Honors:

Emile Colubien Prize 1989-1990

Invited Speaker/Participant (selceted list since 1997):

1997 : March 1316. Palm Springs Symposium on HIV/AIDS "Foundations of HIV therapy. "PMPA treatment of SIV infected macaques: emergence & pathogenesis of PMPAresistant SIV mutants".

May. 47 NCVDG (Washington DC); invited speaker/ Comoderator for Pediatric Prophylaxis Workshop Sept. 36 Invited panel member on expert session; Conference on Global Strategies for the Prevention of HIV transimission from Mothers to Infants

Nov.27Dec 1. International Conference on AIDS India 2000, Chennai (Madras), India.

1998 : Nov. 67. Roundtable Conference: Prevention of HIV Transmission from Mothers to Infants Strategies for India, Chennai (Madras).

Dec. 6-8. 26th Pediatric ACTG meeting (Washington DC): Invited symposium speaker; "Lessons from the SIV/rhesus neonatal model for pediatric HIV/AIDS"

1999 : June 1011. Office of AIDS Research, NH, Working Group to Review NIH Perinatal, Pediatric and Adolescent HIV Research Priorities.

Dec. 6-8 Second International Conference on AIDS India 2000, Chennai (Madras), India.

He has many publications to his credit.

DONALD M.

Messer has served the past 19 years as President and Henry White Warren Professor of Practical Theology at The Iliff School of Theology, Denver, Colorado, USA. He is the author of nine books, including Caught in the Crossfire:Helping Christians Debate Homosexuality. He holds a Ph.D. from Boston University and studied at Madras Christian College, Tambaram, India from 196162. He has previously lectured at AIDS Conferences in the United States, Uruguay, and India.

DR. JORETTA L.MARCHALL

Associate Dean and Associate Professor of Pastoral Care and Counseling at the Iliff school of Theology, Denver, Colorado, USA, is a graduate of Vanderbilt University (M.A., Ph.D.) and of The Iliff School of Theology (M.Div.). She is an ordained clergywoman of the Rocky Mountain Conference of The United Methodist Church, and Participates in the American Association of Pastoral Counselors and the Society for pastoral Theology. Professor Marshall is the author of Counseling Lesbian Partners (Westminister/John knox Press) along with numerous articles in scholarly and religious Journals.

Dr.Marshall's research interests include: feminism, Psychotherapy, and pastoral theology; developmental theory and pastoral care; forgiveness, community and justice; object relations theory and pastoral psychology; as well as introductory courses in pastoral care and counseling.

GNANASWARUPANANDA SWAMI

Joined in Ramakrishna order at Chennai branch in 1985. Trained in the Indian theology, world religions at head quarters of Ramakrishna Math and Mission at Belur Math near Calcutta from 1990-1992. After the training he became the Principal of the Ramakrishna Mission Vidyalaya Central Board School at Agartala in Tripura. He was ordained into the holy monastic vows of the order in the year 1996. He was transferred to the Coimbatore branch of the Ramakrishna Mission in the year 1997. The Coimbatore Vidyalaya is the largest educational complex of the Ramarkrishna Mission in the Wold. Swami Jnanaswarupananda is the Secretary of few schools of this prestigious complex.

The Swami is well versed in Hindu Scriptures with particular emphasis on Ramakrishna Vivekananda literature. Swami Vivekananda's interpretation of religion is most relevent and need of the day. He has given ultimate solutions to practically every burning problem of today's society.

Swami Jnanaswarupananda will deal with the Hindu approach to HIV education & prevention at parallel workshop in (Religion, Ethics, Culture) on December 7th 1999, Monday in the light of the teaching of Swami Vivekananda and his mentor Sri Ramakrishna Paramahasma, saint of modern India.

A. ABDUL RAHIM

Address	:	A100 3rd Avenue, Anna Nagar, Chennai - 102.
Educational Qualification	:	B.Sc., B.L.
Work Experience	:	Practicing As An Advocate Since 1976.
Honorary Posts	:	A) Secretary - MadrasConsumer Courts Bar- Association, Chennai. B) Correspondent, V.T.I. (M.C.S. Baithulmal) Madras. C) Secretary - Mohideen Pitchai Madrasa, Chennai. D) Joint Secretary - Muslim Women Aid Society, Collectorate Building, Chennai. E) Joint Secretary - Jamalia Educational Society, Perambur, Chennai.

ASIR EBENEZER

- Postgraduate in Social work - specialised in Medical & Psychiatric Social work - from the Loyola College, Madras. Unpublished dissertation on "Persistence in Smoking among College students in the city of Madras". *Theological education from the Bishop's College, Calcutta, Serampore University, West Bengal. Unpublished dissertation on "the necessity of religion for human existence in the philosophy of Dr. S. Radhakrishnan".
- While on lien, experimented on neighbourhood rehabilitation program for person with Hansen's disease (leprosy), Non-residential Education Support Program for Children of persons with Hansen's disease to aid the rehabilitation process of the parents, Grassroot education Program on Nutrition for illiterate village women aimed at prevention of illness by altering food habits, and Integrated Supplementary Education Program at the village level for intervention in the area of working children.
- Worked with NGOs and among Care providers in the field of Documentation, Training and Liaison with regard to HIV/AIDS prevention, control and care.
- Presently, Director of the Board of Socio-Economic Concerns, CSI Diocese of Madras, which also includes the responsibility to train Pastors and member of the Christian Church in aspects of Home and Community Care in order that there may be a faithful few who will be able to support persons with HIV/AIDS at the village level when and if the epidemic takes over.

DR. SAVITA PAHWA, MD

POSITION TITLE

Chief, Division of Allergy/Immunology

Professor of Pediatrics

EDUCATION/TRAINING (Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training).

Institution AndLocation	Degree	Years	Field Of Study (If Applicable)
Hindu College, Delhi University	B.S.	1964	Pre-Medical
Lady Harding Medical College, India	M.B.B.S	1970	Medicine & Surgery
American Board of Pediatrics	Diplomate	1970	Pediatrics
American Board of Allergy/Immunology	Diplomate	1970	Allergy/Immunology
American Board of Med Lab/Immunology	Diplomate	1984	Laboratory Immunology
Diagnostic Laboratory Immunology	Diplomateb	1986	Laboratory Immunology

Academic Appointments:

7/81-3/82 Assistant Professor of Pediatrics, Cornell University Medical College.

4/82-6/88 Associate Professor of Pediatrics, Cornell University Medical College.

7/88-6/96 Professor of Pediatrics, Cornell University Medical College.

7/96 Present Professor of Pediatrics, New York University School of Medicine.

Savita Pawha has 171 publications to her credit besides many chapter in text books.

DR.RAMASUBRAMANIAN

He has completed his MBBS form the Madras Medical College and obtained his MD in Internal Medicine from the Post-Graduate Institute of Medical education and Research , Chandigarh, India. After his membership examinations in the U.K., he worked in the Directorate of Infections and Immunity at St. Bartholomews Hospital and the Royal London Hospital. He has presented papers at several international conferences both in India and abroad. His interests include opportunistic infections in HIV, Hepatitis B and nosocomial infections.

CATHERINE PECKHAM CBE

MD FRCP FPHM FRCOG FRCPCH

Catherine Peckham is Professor of paediatric epidemiology and head of the Department of Epidemiology and Public Health at the Institute of Child Health and Great Ormond Street Hospital for Children. She was appointed to the first UK's first Chair of paediatric Epidemiology in 1985 and has contributed across a broad range of subjects including infectious disease epidemiology, vaccination policy, social and biological determinants of health in childhood and adult consequences of childhood disease ill-health. She is particularly known for her work on infections in pregnancy. In 1986 she created the multi-centre European Collaborative Study of HIV infection in mothers and children which was set up to estimate the transmission of HIV infection from mother-to-child, to elucidated risk factors for transmission and to establish the natural history of HIV infection in childhood.

ASHOK PILLAI

Work Experience:

- 1987 -1994 : Served in the Indian Navy as Wireless Operator
- 1994 -1997 : Self Employed : Ran a restaurant in Bareilly
- 1997 -1998 : Served in INP+ as General Secretary. The work involved community mobilisation, strengthening the organisation, advocacy and networking with various organisation.
- 1998 -1999 : 1. Worked as volunteer for INP+. The work; involved advocacy, proposal writing, assisting management of INP+ in day to day tasks, training programs and office work. 2. Representing PWA community of India in Asia Pacific Network for People living with HIV/AIDS(APN+) and APN+ rep to Global Network for People living with HIV/AIDS(GNP+).
- 1999 -Till todate : Elected as President of INP+. The work involves management, policy making, networking, advocacy and training.

DR. PREM CHANDRAN JOHN

Early school and college education in Madras. Medicine from Vellore and a Masters degree in International Health Planning from Johns Hopkins. Sixteen years grass roots involvement with health activism of the poor in southern India and seventeen years as Coordinator of Asican Communicyt Health Action Network promoting peolple-based health systems in Asia. Numerous studies and publications on poverty, inequality, health and justice.

D13-325
05137 N79
COMMUNITY HEALTH
LIBRARY
AND

DR. MINI JACOB MBBS,MD

Dr. Mini Jacob graduated from Dr. BR Ambedkar Medical College, Bangalore, thereafter was a senior house surgeon in St. John's Medical Coliege, Bangalore. She did her Post Graduation in Dr.AL Mudallar Post Graduate Institute of Basic Medical Sciences, Chennai. She has been working as Research Officer in the Department of Experimental Medicine, Tamil Nadu Dr. MGR Medical University for past 5 years. Her nature of work includes drug assay,viral load estimation in HIV patients by RT PCR and bDNA.She has been a faculty member for many training programs conducted by the Department. She has undergone HIV training program at KIS Hospital, Munich, Germany. She has attended and presented paper at the 12th World AIDS Conference in Geneva and has attended the 2nd Global Strategies in the prevention of mother to child transmission at Montreal, Canada.

DR. MILTON TAM

Milton Tam is Technical Director for diagnostics development for PATH's Seattle Program Site. Dr. Tam is responsible for coordination of inhouse development of appropriate, cost effective diagnostic tests for manufacture, distribution, and use in developing countries. Dipstick assays for HIV1/HIV2 and hepatitis B surface antigen and tuberculosis have been completed, and the manufacturing technology has been transferred to recipients in several developing countries. Current developments are focused on a new generation of rapid, simple assays for infectious diseases. Under the Technologies for Child Health (Health Tech) project, Dr.Tam directs the development, field evaluation, and technology transfer of simple and rapid diagnostic test kits for infectious diseases, including tropical and sexually transmitted diseases. He also coordinates PATH's activities as a Participating Centre for the STD Diagnostics Initiative, a worldwide network of STD experts based at the World Health Organization in Geneva, Switzerland. Before coming to PATH, Dr.Tam led a research group for infectious disease diagnostic test development at Genetic Systems/Sanofi and has worked in retrovirus and cellular immunology research at the Fred Hutchinson Cancer Research Institute. He holds an A.B. in microbiology from the University of California, Berkeley; a M.S. in virology from the University of Michigan; and a Ph.D.in immunology from the University of Washington. Dr.Tam recived postddoctoral training at the University of California, Los Angeles, and the University of Otago, New Zealand.

SUSAN BEST

6 Forest Street, Collingwood
VIC Australia 3066
Phone (BH): 039418 1123
Phone (AH): 0394193048

Education

University Education RMIT University, Melbourne 1992-1998
Master of Applied Science by Research
Title of Thesis Optimisation of parameters for Polymerase chain reaction for the detection of HIV-l DNA.

Royal Melbourne Institute of Technology, Melbourne 1973

Diploma of Medical Laboratory Technology

Our Lady of the sacred heart college, Melbourne victoria Matriculation.

Professional Employment

National Serology Reference Laboratory, (Australia)

1995 - Current Senior Scientist

April'99- July'99
Acting Director

Responsibilities

Deputises for the Director in her absence.

Coordinates NRL staff and allocates tasks to ensure projects proceed in a timely manner. This includes liaison with other laboratory personnel, government officials, medical officers, manufacturers and others who have contact with the laboratory.

In areas of expertise supervises other members of the NRL staff and undertakes teaching roles. Directs the establishment optimisation and maintenance of molecular techniques (PCR for HIV1, HIV2, HTLV HCV). Coordinates the national evaluations of test kits. Trains NRL staff and fellows as well as maintains laboratory protocols.

DR. SRIKANTH TRIPATHY

Qualifications :

- MBBS (Madras Medical College, Chennai,1982)
- M.D.General Medicine (Madras Medical College,Chenai ,1987)
- 1986 to 1988: Research Officer ,Tuberculosis Research Centre, Chennai
- 1988 to 1990: Research Officer, HIV Surveillance Centre, AIIMS, New Delhi
- 1991 to 1992 :Senior Research Officer ,National Institute of Virology,Pune
- 1993 TO 1996: Senior Research Officer ,National AIDS Research Institute , Pune
- 1996 till now: Assistant Director National AIDS Research Institute , Pune
- Have been involved in seroepidemilogical and molecular epidemiological studies related to HIV virus and also in the clinical management of HIV infected individuals over the past 10 years initially in Delhi and then in Pune.

DR.M.SURESH KUMAR MD DPM MPH (USA)

- Psychiatrist and Medical Officer in charge, Deaddiction Unit, Institute of Mental Health, Chennai.
- Honorary Consultant, SAHAI Trust for Drug Abuse Prevention and Treatment-Outreach Projects, Chennai and Rehabilitation Centre, Covelong, Chengai District.
- Has been actively involved with research in the field of Substance abuse and HIV prevention among drug users. Served as Principal Investigator for many research projects on Substance Abuse supported by various agencies including WHO, Indian Council of Medical Research, Ministry of Welfare, Govt. of India, and Caritas Netherlands. Involved in International Epidemiology studies in Substance abuse.
- Has presented original scientific papers at National and International Conferences. Has several publications in National and International Journals. National and International Monographs and Text Books.
- Hubert Humphrey Fellow-Us Govt sponsored Fellowship in Substance Abuse at Johns Hopkins University Baltimore, USA. 1994-95.
- Founder Member and Steering Committee Member-Global Research Network on HIV Prevention among drug using populations.
- Member, Asian Multicity Epidemiology Workgroup on Substance Abuse.
- Recipient of several NIDA-INVEST USA sponsored Travel Awards for attending premier meetings and conferences on Substance Abuse at USA, Europe and East Asia.
- International Consultant to WHO/UNAIDS for developing HIV prevention strategies for drug users in Central Asain Countries. Involved with HIV intervention development for the Health ministry of Kazaksthan.
- Teaching and training medical officers, social workers, psychologists, field workers, postgraduate students in psychiatry, psychology, social work, nursing and criminology in the field of addictive behaviour. Training research workers in research methodology, rapid assessment methods and intervention development.

I.S. GILADA

Born in a large orthodox family of Latur and brought up with lots of hardship. Dr. Ishwarprasad Satyanarayan Gilada has come a long way in bringing India on AIDS control map of the world, carrying out social reforms through medical profession in tackling sensitive issues like prostitution and sexuality. A teetotaler all along he has a very supportive wife and two daughters. After passing MBBS from Aurangabad, he worked as Resident Medical Officer in Skin and STD Dept. at the government run J.J.Hospital, Mumbai for 10 years till 1991. During his service career, he did his post-graduate diploma and fellowship in Skin and STD. His dissertation "Pattern of STDs among Hijras" has been internationally acclaimed and fetched him the Diplomate of American Board of Sexology. He did Clinical training in AIDS at San Francisco General Hospital and University of Medicine & Dentistry, New Jersey, USA in 1987 and was the first doctor from India to have received such a training in AIDS.

He has trained several students, doctors, nurses, social workers and counsellors during 17 years of his professional career. To develop a voluntary Corp to tackle medico-social problems of the poor and hapless in India, he had established and has been managing Indian Health Organisation (IHO), now Peoples Health Organisation (India) since April, 1982; which is acclaimed for its intervention projects in AIDS and prostitution. The U.S.- India Business Council, named IHO the most outstanding Indian NGO in 1997. He had established Asian Solidarity against AIDS in 1991 and he is Secretary General of ASAA since then. He is the Editor.

DR. GRACE JOHN

Office Addresses :

1) IARTP
University of Washington
Box 359909, Seattle
. Washington 98 104-2499

Phone : 206-731-2822

Fax: 206-731-2427

Email: gjohn@u.washigton.edu

2) Medical Microbiology Annexe
P.O Box 19676
University of Nairobi, Kenya

011-2542-722-762

011-2542-722-762

gjohn@africaonline.co.ke

Faculty Positions

1993-present	Visiting Research Scientist University of Nairobi, Nairobi, Kenya
1996-1997	Acting Instructor, Department of Medicine University of Washington
1997-present	Assistant Professor, Department of Medicine University of Washington

Professional Organizations

1987-1989	American Medical Student Association
1987-1990	American Medical Assiciation
1997-1993	American Academy of Pediatrics
1987-1992	American College of Physicians
1993-present	Network of AIDS Researchers in Southern and East Africa (NARESA)

Dr. Grace John has several publications in International Journals.

DR. JULIANA MCELRATH M.

Education : 1978 Ph.D., Medical University of South Carolina, Charleston, South Carolina 1980 M.D., Medical University of South Carolina, Charleston, South Carolina

Faculty Positions:

1988-89 Assistant Professor, Laboratory of Cellular Physiology and Immunology, The Rockefeller University

1990-96 Assistant Professor, Department of Medicine, University o f Washington, Seattle, WA

1996-Present Associate Professor, Department of Medicine, University of Washington, Seattle, WA

1996 - Present Associate Member, Fred Hutchinson Cancer Research Centre, Seattle, WA

Administrative Positions:

1990-91 Medical Director, Harborview Medical Centre AIDSclinic

1991 - Present Director, University of Washington AIDS Vaccine Evaluation Unit

1997 - Present Associate Head, Program in Infectious Diseases, FHCRC Clinical Research Division

Hospital Positions:

1987-89 Associate Physician, The Rockefeller University Hospital

1987-89 Physician Consultant, The Rockefeller University Employee Health Office

1990 Present Consulting Physician, Department of Medicine and Division of Infectious Diseases,UW Medical Centre, Harborview Medical Centre and Fred Hutchinson Cancer Research Centre.

DR. RAMESH SHIVARAMAN PARANJAPE Ph.D

Work Experience
Tuberculosis Research Centre (1976-1993)
National AIDS Research Institute (1993-to date)

Area of Research

The main field of research was immunological studies in tuberculosis and filariasis. Standardisation of techniques such as netralizing antibody assay, culture of HIV from peripheral blood mononuclear cells of infected persons. Antigen induced proliferation of lymphocytes and assays for HIV-specific memory CTLs are also being carried out in the laboratory.

Publications

Over 25 in national and international journals.

Prof .C.N. DEIVANAYAGAM

MBBS, FRCP (Edin)

Education : MBBS at Madras Medical College and Govt General Hospital, Chennai.3 in 1965 with Johnston Gold Medal for the best out going student of the college, 1965-66.

Trained in U.K., 1967-1970.

Internal Medicine and Chest Diseases- Clinical attachment to Prof John Crofton of Edinburgh-1969.

Sr.Research Officer, B.M.R.C., Pneumoconiosis unit, at Penarth, Glam, United Kingdom, 1969-1970.

Asst Professor of Chest Diseases

Madras Medical College, 1970-1981.

Professor of Thoracic Medicine ,Madras Medical College and Stanley Medical College, 1981-till date.

Dean and later Director-in-charge of the Tamilnadu Arasu Medical Science and Research Institute (TAMARAI), Porur, 1989-1992 (now Sri Ramachandra Medical College and Research Institute).

Superintendent, Govt Hospital of Thoracic Medicine Chennai 47, 1992-till date.

This hospital at Tambaram is now the largest AIDS Care Hospital, in India, currently housing more than 450 In-patients, in advanced state of AIDS with complications. So far, more than 12,000 patients have been investigated and treated for HIV infection and disease in this hospital from 1992 (mainly as out patients).

Published articles on TB and Lung Diseases in various journals.

Editor of Lung India, the official organ of Indian Chest Society- 1982-1996.

Invited to deliver a lecture on ``Tropical Pulmonary Eosinophillia" atStockholm in 1996 Europeal Respiratory Society-Annual Conference.

Now active Research in HIV, TB is undertaken at G.H.T.M Chennai ,Collaborating with ICMR, TRC and Several leading Siddha Practitioners.

President, T.N.Chapter of Indian Association on Tobacco and Health.

Convenor of Physicians for Peace, Tamilnadu.

President of Kalvi Pani, an Educational Trust running several schools and Training Institute in Tamilnadu.

Many Health related articles published in News papers.

Talks in Doordarshan and Radio, concerning Pulmonary Health and Tobacco.

Paper setter and Examiner for DTCD, MD, DM (Pulmonary Diseases) as well as Dip NBE.

President of Tamilnadu Chapter of Indian Chest Society conducting Monthly Meeting at Major Hospitals at Chennai.

PROF. P. JEYAPRAKASH NARAYANAN

B.I.M 1971 - Madurai Kamaraj University M.D.(SIDDHA) - 1975.

Present Position : Vice Principal Professor and Head - Dept. of Special Medicine (Sirappu Maruthuvam) Govt. Siddha Medical College Chennai - 600 106.

Experience : Assistant Lecturer Government Siddha Medical College ('76-77')

Presentation of "Indian Systems of Medicine" - (San Francisco Mutual Programme sponsored by papers in the :Madurai Kamaraj University - 1978) scientific forums

"Health for all by 2000A.D. Role of Siddha Medicine"(Sponsored by SociologyDepartment of the Madurai Kamaraj University - 1978.)

"Survey of Intra Abdominal Tumours" Cancer workshop sponsored byCentral council forResearch in Ayurveda and Siddha held at Chennai (1986)

Ano Rectal Disorders a comparative study - Cancer Workshop (1986)

"Comparative Study on Urethritis" National Conference in Siddha a Medicine, Trivandrum (1990.)

"Mercurial Preparations of Siddha Medicine" Siddha Conference sponsored by Thanjai Saraswathy Mahal Library (1990) held at Government Siddha Medical College, Palayamkottai (1990).

YUGI'S View on Vascular Disorders - Siddha Conference sponsored by Thanjai Saraswathi Mahal Library (1990).

"Male Sexual Inadequacy and Its Management in Siddha Medicine"4th World Congress holistic Approach - Bangalore (December 1991).

Talk on "Male Sexual Inadequacy" National Conference on Integrated MedicalPractice Today - IMP 1991 (Chennai, November 1991)

Guest Lecture on Nirizhivu Noi (Diabetes Mellitus)Seminar on Diabetes Mellitus (Sponsored by Central Council for Research in Ayurvedha & Siddha) Chennai27.03.98.

Guest Lecture on Siddha Medicine and their Quality Control - National ScienceAcademy 64th Anniversary held at Chennai (November 1998)

Guest Lecture on "Mother Induced Hypersensitivity in the foetus and Children - (Seminar of Niamath Science Academy, Chennai (7.08.99).

DR. K. SOUNDARA PANDIAN

Age : 59 Years

Qualification : Medical. B.A., M.B.B.S., D.P.H.,F.I.S.C.D.,

Experience : Before Government Service

- Lecture in Health Education at Gandhigram Institute of Rural Health and Family Welfare (For 7 Years)

In Government Service

- Municipal Health Officer
- District Health Oficer
- Corporation Health Oficer
- Deputy Director of Health Officer

in all over TamilNadu

After retirement from Government Service

- as a Principal in Gandhigram Institute of Rural Health and Family Welfare
(Regional Training Centre)

- Now, As a Consultant in the Department of Community Medicine in Meenakshi Mission Hospital and Research Centre, Madurai.

DR. R. LAKSHMI
M.D (S)

Designation	:	Lecturer Govt. Siddha Medical College Palayamkottai - 627 002
Experience	:	18 yrs & 10 months
Graduation Both U.G & P.G	:	From Govt. Siddha Medical Palayamkottai - 627 002

Interested in Research - AIDS & CANCER

DR. RAMAN R. GANGAKHEDKAR
Senior Research Officer,
National AIDS Research Institute,
POB 1895, Bhosari,
Pune-411 026

And

Editor,
Quarterly, AIDS Research & Review

Fellowships Awarded:

Fogarty' Fellewshlp, National Institute of Health. USA for doing Master of Public Health (MPH) at Johns Hopkins University, Paltimore, USA from July 1995 to May 1996.

FXB Fellowship, Francoise Xavier Bagnoud Foundation, Switzerlands for training on Clinical Management of Pediatric AlDS of National Pediatric HIV Research Center. New york, USA in June 1996.

ICMR Fellowship for a training entitled A Controlled Clinical Trials = at the Institute for Research in Medical Statistics. Chennai between March I7-27, 1997 .

DR. C. ALAMELU

Place of work	:	Department of Experimental Medicine TN Dr. MGR Medical University 40, Anna Salai Guindy, Chennai - 600 032
Qualification	:	M.Sc,Ph.D
Ph.D Thesis work	:	Evaluation of mycobacterial antigens in serodiagnosis of tuberculosis.
Other Areas	:	Worked on few Projects HIV/AIDS Have exposure to several Immunology and molecular biology techniques. Served as faculty member in the departmental training p rogrammes.

DR. K.MARY SUSHI

Place of work	:	Research Assistant Department of Experimental Medicine TN Dr. MGR Medical University Chennai 600 032
Qualification	:	M.Sc,M.Phil,Ph.D
Present research work	:	Involved in the field of HIV/AIDS for the past four years. Performance of Elisa, Western Blot assays. Diagnosis of Leptospira using Microscopic Agglutination Test.

DR. SUNITI SOLOMON MBBS, MD

SERVICE/ WORK EXPERIENCE

From 1986, Dr. Solomon has been involved in promoting AIDS awareness. Her team documented the first evidence of HIV infection in India. In 1987, with financial support from the Indian Council for Medical Research, she set up the first voluntary testing and counselling centre and an AIDS Resource Group in Madras. Through the AIDS Resource Group she began education and prevention programmes in HIV/ AIDS for adolescents and young adults. In 1994, she sought voluntary retirement from the Madras Medical College and founded the YRG Centre for AIDS Research and Education, an autonomous unit of the Y.R.Gaitonde Centre for AIDS Research and Education, a registered charitable trust.

AREA OF RESEARCH

She is the principal investigator of the British Council Division supported Indo-UK Link Project on HIV, one of the earliest collaborative studies in herbal therapy for HIV, conducted jointly by the YRG Centre for AIDS Research and Education, the Dr.ALM Post Graduate Institute of Basic Medcial sciences, Tharamani and the Ruchill Hospital at Glasgow. As Principal Investigator of the prevalence study on HIV I and HIV 2 in Tamil Nadu, supported by the Agency for Cooperation in International Health, Japan, she documented the widespread prevalence of HIV in rural populations. Her laboratory assesses the sensitivity and specifity of non-invasive HIV diagnostic tests, such as the Saliva and Urine tests, for leading pharmaceutical research laboratories around the world.

Publications:

She has particpated in several international conferences on HIV/AIDS and has published several papers in India and Internaitonal Journals on epidemiological, social and clinical aspects of HIV and AIDS.

DR CARL POMMER

Proffessional Experience:

- Since 1955 International Marketing Manager Virology & Immunology, HIV Products.
- 1994 - 1998 Member of the Board of Directors of NeoRx, Seatlle,USA.
- 1993-1997 Head of International Hospital Product Marketing
- 1991-1993 International Manager of New Biological Agents
- 1987-1991 Head of Product Group III within International Hospital Product Marketing
- 1994-1998 International Product Manager for ACTILYSE\
- 1984-1992 International and overal project manager for the t-PA project, reporting
  directly to the Chairman of the Board of Managing Directors
- 1981-1984 Bsiness Development and licensing manager for the anglosaxan world
- 1976-1980 Area Manager for the USA and Canada
- 1976 Joining Boehringer Ingelheim Corporate office in Ingelheim
- 1967-1969 Military Service,Air Force
- 1966-1967 Technical employee ,Carl Pommer ,leather factory

Education:

- 1970-1976 University of mannheim: marketing and trade university of Goettingen: Business Administration ,Political Economics, Social and Economical History Exam: Diplom-Kaufmann{MBA,Economist}

Publications:

- .G. Warner and C.-H.Pommer :Successful Development of Recombinant DNA-Derived Pharmaceuticals , In: Arzneimittel-Forsching /Drug Research 40 [II], II, 1274 -1283 {1990}

DR.N.S.MURALI

No.22 III Street
Palmgrove Colony
Royapettah High Road
Chennai -600 004

Professional qualification :

Year of passing	Name of University
MBBS	Dec. 1956 Madras University
MS	March 1964 Madras University
FICS	1978 International College of surgeons

Experiece after postgraduation :

He has got 33 yrs of Professional Experience in Governmental General Hospital and 12 yrs of Teaching Experience at GH and VHS.

Working as Professor of Surgery at Ragas Dental College, Chennai.

As honorary Secretary at VHS from March 1985.
He has got several publications.

DR.J.S.RAJKUMAR

47/3, New Avadi Road, Kilpauk,
Chennai 600 010.
rigid @md 2, vsnl. Net.in

Educational Qualification :

- MBBS 1985 University of Madras (1 Rank)
- MS 1989 University of Madras (1 Rank)
- FRCS (Edinburgh) 1989 Royal College of Surgeons, Edinburgh.
- FRCS(England) 1990 Royal College of Surgeons, England.
- FRCS(Glasgow) 1990 Royal College of Surgeons, Glasgow.
- FRCS (Ireland) 1990 Royal College of Surgeons, Ireland.
- Dip.National Board (Surgery) 1997 National Board of Examinations, New Delhi| National gold Medal.
- FICS 1997 International College of Surgeons, Chicago.
- FAIS 1998 Association of Surgeons of India.
- FIMSA 1999 International Medical Sciences Academy, Mumbai.

Current Post : Chief Surgeon - Dr. Rajarathinam Institute of Gastro Intestinal Diseases, Chennai.

DR NAFEES AHMAD Ph.D.

Position Title: Associate Professor Date of Birth: 1/24/59 Mailing Address: Department of Microbiology & Immunology, College of Medicine. University of Anzona, Tucson, AZ 85724 Tel. 520-626-7022 Fax. 520-626-2100 e-mail; nafees@u.arizona.edu EDUCATION B.Sc. (Hons) (1974-1976) Department of Chemistry, Aligarh Muslim University (AMU). Aligarh, India. M.Sc (1978-1978) Department of Biochemistry. Faculty of Life Sciences. AMU. Aligarh, India .M.Phil. (1^"8-1980) Department of Biochemistry. Central Dnig Research Institute (CDRI). Lucknow and Department of Biochemistry. Facility of Life Sciences, AMU, Aligarh, India. Ph.D. (1980-1983) Department of Biochimerstry. CDRL. Lucknow and Dept. of Biochemistry Faculty of Life Sciences. AMU. Aligarh, India. Post-Doc (1985-1988) Laboratory of Molecular Microbiology. National Institute of Allergy and infections Diseases (NIAID). National Institutes of Health (NIH), Bethesda, Maryland, USA.

Research interests and experience :

Molecular mechanisms of HIV-1 mother-infant transmission (1990 - todate)

Pathogenesis of HIV-1 infection in infants (1990-todate)

Molecular biology of Human Immunodeficiency Virus (1985- todate)

Molecular pathogenesis of HCV infection (1990 - todate)

Teaching Experience:

Teach Medical Virology to second year M.D. Students of the College of Medicine, Univ. Of Arizona.

Teach Molecular and Tumor virology to Ph.D. Students of Microbiology and immunology program.

AIDS Education and awareness throughout the University campus and high schools in Arizona.

He has got publications to his credit in reputed Journals.

DR. RASHID H. MERCHANT

Dean & Professor of Pediatrics

Babi Jerbai Wadia Hospital for Children

Parel, Mumbai

Affliated to Seth G.S. Medical College, Bombay University

Director Neonatal Services, Nowrosjee Wadia Maternity Hospital

Director Perinatal & Pediatric HIV Program, Wadia Hospitals

Ex-Fellow Neonatalogy, Wayne State University, Michigan, USA

Areas of Academic Interest : 1) Perinatal Medicine

2) Perinatal & Pediatric HIV/AIDS

DR. VIMALA RAMALINGAM

Designation : Joint Director (Blood Safety) Tamil Nadu State
AIDS Control Society, 417 Pantheon Road,
Egmore, Chennai 600 008. TamilNadu, India.

Qualifications : Madras University MBBS March 1967
Madras University DCH Oct 1969
Madras University M.D., March 1979 (paed)

Presented papers in both National and Institutional Conferences.

Chairman of the Ethical Committee for Siddha Drug Trial in HIV/AIDS patients in Tamil Nadu State AIDS Control Society.

Experience in Women and AIDS

Coordinator of the Women and AIDS Adhoc Committee, Tamil Nadu State AIDS control Society working with the various women organisations for the women welfare education and empowerment in AIDS and other Social Issues.

DR.REMA MENON

Dr. Rema Menon is the blood bank officer in charge of the IMA Blood Bank since 1995. worked in the Kidwai Cancer Institute, Bangalore and private hospitals in Kerala for nearly 10 years before taking on this position. She is also the Project Coordinator of the State's only HIV/AIDS Counselling Centre- ASHRAYA since 1997.

Workshops/Seminars

Attended the Counselling Training workshop at CMC Vellore in 1993. Underwent the NACO-Core Training for Trainers in 1995.

Has attended training programs in blood banking organized by the WHO-State AIDS Cell in Kerala since 1995.

Has been working as a resource program in the training programs for Medical officers and paramedical staff conducted by the State AIDS Cell in Kerala.

Member

- Kerala State Transfusion Council
- Transfusion Council of the Union Territory of Lakshadweep.
- Member of the AIDS society of State IMA
- President of the Partner's Forum-A professional body of NGOs working in the preventive Sexual Health Projects in Kerala

Publications and Presentations

Articles in the popular Malayalam and English Magazines in Kerala related to HIV/AIDS and Blood Banking

Talk shows on HIV/AIDS and Blood banking in local AIR and Television channels.

Presented a paper titled "Migrant Workers and the problem of HIV/AIDS in Kerala at the First International Conference on AIDS INDIA 2000 Held at Chennai in 1997.

Participated at the Round Table Conference -Prevention of HIV Transmission From Mother to Infants-Strategies for India at Chennai in 1998.

DR N. B. JAJU

Personal Details :

Qualification	: MD DCH
Designation Bank	: Head of Thalassemia Unit & Regional Blood StGeorge's Hospital, Fort, Mumbai 400 001.
Address	: RMO Quarters, 1st Floor, StGeorge's Hospital, Fort, Mumbai 400 001.
Email	: nbjaju@globin.com

Special Interest :

• Transfusion Medicine, Thalassemia, AIDS, Hospital Administration

Training :

• Trained in Blood Banking Technology and Hematology, Haemophilia, Blood Components, Advanced Immuno-hematology and Computer Science
- Office Automation.

Participation & Reasearch Work :

• Growth hormone levels in Thalassemia
• Blood transfusion in Thalassemia - Scenario in Bombay-
• Research study in Blood disorders-WHO Country Programme.
* Transfusion induced HIV in India.

Prof. K.M. RADHAKRISHNAN

Qualification : M.B.B.S., D.C.P

Present Position : Special Officer,
Dept. of Transfusion Medicine,

The Tamil Nadu Dr.M.G.R. Medical University,

Chennai-32.

Previous Positions held: Additional Director of Medical Education & State Transfusion Officer, Govt. of Tamil Nadu Project Leader, State AIDS Project Cell in the rank of Addl. DME, Govt. of Tamil Nadu

Deputy Director of Medical Education, Planning & Development, Govt. of Tamil Nadu.

Professor of Blood Transfusion in Kilpauk Medical College & Stanley Medical College.

Civil Surgeon, Primary Health Centres, Govt. of Tamil Nadu; Officer incharge, Clinical Laboratory, Govt. Royapettah Hospital; Worked as Asst.Surgeon Under the Directorate of Medical Services.

Academic Activities : Participated and presented scientific papers, nation wide and International.

DR. PRATHAP THARYAN

Department of Psychiatry -Unit II. Christian Medical College,
Vellore-632002, Tamil Nadu, India
Tel: (01416) 222603 Ext 42594264
Fax: (0416) 232268 232788
e-mail: prathap@mhc.cmc.ernet.in
prathap-tharyan@hotmail.com

Qualifications:

- M.B.B.S. 1981 Christian Medical College, Vellore
- M.D. (Psychiatry). 1987 Christian Medical College, Vellore.
- M.R.C. Psych 1995 Oxford, UK.

Special Interests:

- Systematic Reviews and Evidence Based Medicine: Member of the Cochrane Schizophrenia Group and the Cochrane Collaboration. Conducting workshops in meta-analysis and systematic reviews for intramural and extramural personnel.
- Clinical Epidemiology: Member of the Clinical Epidemiological Unit, Christian Medical College Hospital and INDIACLEN (Indian Clinical Epidemiology Network), and associate member of INCLEN. Member of the research committee of the Christian Medical College that scrutinises all institutional research applications.
- Neuropsychiatry : Member of the Intractable Epilepsy Management team in collaboration with the Department of Neurosciences, CMC Hospital.
- Counselling for HIV~ AIDS prevention and care: Member of the steering committee on counselling issues of the National Aids Council Project Director of the Resource & Reference Centre for the Psychosocial aspects of AIDS funded by the Ford foundation and the Counselling Training Project (APAC) funded by USAID that provides training in counselling for prevention of sexually transmissible diseases including HIV and in providing affirmative Care for people living with HIV AIDS.
- He was a member of CME for Gps and Indian Psychiatric Society.
- He has Several publication Nation and International Journals.

Dr. S. AARTHI M.D. DipNB, MRCOG

Consultant Obstetrician & Gynaecologist,
Laxmi Nursing Home,
Melapalayam East Car street,
Ambasamudram,
Tirunelveli Dist.

M.B.B.S.	-	March 1993 PSG Institute of Medical Sciences & Research Coimbatore.
M.D. {O.G}	-	September 1997 Institute of Obstetrices & Gynaecology, Chennai Medical College, Chennai.
Dip NB{O.G}	-	September 1998
MRCOG	-	May 1999 Royal College of Obstetricians & Gynaecologists.

DR. G. MANOHARAN

Academic Qualification : MBBS 1979 Madras University MD 1982 Madras University

Professional Experience : 1995 August - Till

Professor & HOD of Medicine & Project Co ordinator of AIDS

Ward I/C, IRT-Perundurai Medical College & Research Centre, Perundurai

From 1982 - 1994 - Served as Assistant Prof. In Saveeta Dental College, Sri Ramakrishna Hospital, Coimbatore.

PSG Institute of Medical Science & Research, Coimbatore.

1994-95 Associate professor

Department of Medicine

RT - Perundurai Medical Collegeand Research, Tamilnadu

1992-94 Associate Professor Of Medicine Experience Abroad Chief Of Medical Department, Al-hurriya Hospital, Tobruk, Libya

Researwork: Had presented papers and have a No.of Publications in many typics RenalChanges in cirrhosis Liver, - Tuberculoma in Brain & HIV & AIDS - Elderly mitral stenosis

DR.(MRS.) P. MANORAMA

102a, Rangarajapuram Main Road,
Kodambakkam, Chennai -600 024
Telephone : 91-044-4726655
Fax : 91 -044-4840148
e-mail :pmr@md3.vsnl.net.in

Educational Qualifications : M.B.B.S., D.C.H., M.D. (Paed);D.M.(Gastro), F.A.G.E.,

Present Position : Founder President Of Ches.

Special Social Services :

- Taking care of AIDS orphans since 1994.
- Interested in the uplift of women in weaker and vulnerable section.
- Interested in the recognition and social acceptance of eunuchs.
- Taking care of HIV positive people and AIDS patients in a holistic manner.

Conferences Attended:

Dr.P. Manorama has attended six National and eight Regional Pediatric conferences. She has attended over 25 workshops in the field of AIDS. She has chaired many sessions in both the fields of her interest.

Research Work & Publications:

She has done extensive research in the field of pediatrics with special reference to infectious diseases, diarrhoeal diseases, chronic diarrhoeal diseases and its management, Total Parental Nutrition, liver diseases, ral dehydration therapy, childhood leprosy and pediatric AIDS. She has published 15 papers in Regional & National journal of Pediatrics. She has publications in many regional, state ad national journals. Her work was appreciated as COVER STORY in an International AIDS magazine called IMPACT ON HIV/AIDS, from WASHINGTON.

YASMIN HAIMA

Education:

Educational Research and Clinical Psychology, BA Hons.

Professional Experience:

Researcher, Primary Care Management, Department of Health (1991-1993)

Health Strategy Officer, Health and Local Authority (1993-1996)

HIV Client Support Coordinator, Naz Project London (1996-1998)

HIV Development Manager and Treatment Advocate, AIDS Treatment Project (1998-1999)

Member of the European AIDS Treatment Group (since 1997)

Member of the European AIDS Community Advisory Board (since 1997)

Member of the XX Women's Working Group/ECAB (since its inception, 1999)

Treatment Journalist for the European AIDS Treatment News, EATG and newsletters for the ethnic minority communities in the UK

Trainer and Consultant to NGOs and the statutory sector.

CONSTANCE L. BLOWERS

Director, HIV Policy & External Relations
Glaxo Wellcome, Research Triangle Park, NC

Twenty-five (25) years experience in the global pharmaceutical industry involving basic, clinical research (phases I-IV) and scientific/medical pre-marketing programs. Nineteen (19) years of U.S. and international management experience in multi-cultural environments. Current responsibilities include developing international HIV/AIDS policy recommendations and position papers for Glaxo Wellcome, developing and maintaining relationships with international healthcare coalitions and agencies and representing Glaxo Wellcome (GW) and Company policies externally in a variety of national/international medical, commercial and political forums.

DR.HEIDEMARIE KREMER M.D

1983-1990 Study of Medicine in Germany 1990-1996 Specialisation in Internal Medicine in UK and Germany including complementary medicine in HIV since 1998 study of Psychology in Germany AIDS Activities since 1998 in self-support - settings,women's issues, treament activism,HIV/AIDS education: BODmember of All Around AIDS e.V., Germany since1993 member of the German network women and AIDS since 1995 editing in treament journalism for Project Information Munich since 1997 member of German Community Advisory Board since 1999 participation in European Aids Treament group EATG and European Community Advisory Board since 1999 member of XX-Study -Group /EATG since 1999.

SUBHASREE SAI RAGHAVAN

Academic Training:

1985	B.Sc. (Human Nutrition), Sri Satya Sai Institute of Higher Learning, India
1987	M.Sc. (Human Nutrition), Sri Satya Sai Institute of Higher Learning, India.
1992	Ph.D. (Human Nutrition), SNDT Women's University, Bombay, India.

Post Doctoral Training:

1995	Post Doc. (Public Health Nutrition), College of Physicians & Surgeons, Columbia University.

Academic Appointments:

1999-present	Assistant Professor in Clinical Nutrition Medicine, Department of Medicine, Columbia University, New York
1995-present	Program Coordinator, HIV-Nutrition Research Division of Infectious Diseases, Harlem Hospital Center, New York
1995-present	The Institute of Human Nutrition, College of Physicians & Surgeons of Columbia University, New York
	Faculty, Thesis Preceptor and Course Co-coordinator of Grants Course
1995 Jan -	Institute of Human Nutrition, College of Physicians & Surgeons, Columbia
1995 April	University, New York

Associate Research Scientist.

1993 -1995	Institute of Human Nutrition, College of Physicians & Surgeons Columbia University, New York.
	Post Doctoral Research Scientist.
	1990 -1992 SNDT Women's University, Bombay, India,Lecturer in Human Nutrition.

Other Professional Activities: Clinical Trials:

Chair :	Metabolic Consequences of Highly Active Antiretroviral Therapy (HAART) in HIV-Positive Individuals A proposed multi-center study of the Terry Beirn Community Programs for Clinical Research

on AIDS (CPCRA), Sponsored by National Institute of Allergy and Infectious Diseases (NIAID) of the National Institute of health (NIH).

Member: An open label randomized three arm comparative trial of a caloric supplement with peptides and medium chain tryglycerides vs a caloric supplement with whole protein and long chain tryglycerides vs no caloric supplement/or the prevention of weight loss in individuals with AIDS:

A completed multi-center study of the Terry Beirn Community Programs for Clinical Research on AIDS (CPCRA), National Institute of Allergy and Infectious Diseases (NIAID) of the National Institute of health (NIH).

Consultations:

1993-1995	Studies on growth failure and body composition alterations in HIV-Infected children, Program for Families and Children, St. Luke's Hospital Center, Columbia University, New York.
1994 -1995	Studies of growth failure in HIV-Infected children in Zambia, Center for Infectious Diseases. University of Texas School of Medicine and the School of Public Health, Houston, TX
1995	Studies of growth failure in HIV-Infected children, Incarnation Children Cent.er for HIV Infected Children, College of Physicians & Surgeons of Columbia University, NY
1996-present	Medical Grand Rounds.

She has several publications to her credit.

Tmt.V.G.SUNDARI, M.E

WORK EXPERIENCE

Presently Lecturer, Department of Experimental Medicine & SMIC, TN Dr.MGR Medical University. Has been trained in laboratory techniques like HPLC, Electrophoresis Spectrophotometer analysis etc.

CONFERENCES/ WORKSHOPS

Assisting the post graduate and research scholars of medical and non-medical sciences in standardising techniques and instrument operations.

Assisting the project co-ordinator of AIDS projects of the TN Dr.MGR Medical University in conducting AIDS workshops, training programmes and conducting conferences.

Participated in the International course on AIDS prevention and care in ASIA from 30th October to December '95 in Tokyo. Japan.

DOLLY DANIEL

Pathologist, currently working as senior lecture and acting head, department of clinical pathology, Christian, Medical College & Hospital Vellore, India.

Deal with laboratory hematology with especial areas of interest being blood banking and tissue typing.

JOHN G. MCNEIL M.D., M.P.H.

Profession Experience:

1993-present Chief, Department of HIV Vaccine Development, Division of Retrovirology, Walter Reed Army Institute of Research, Washington, DC

1991-1993 Chief, International Program, Military Medical Consortium for Applied Retroviral Research, Walter Reed Army Institute of Research, Washington, DC

1986-1993 Chief, Epidemiology Studies Branch, Department of Epidemiology, Division of Preventive Medicine, Water Reed Army Institute of Research , Washington, DC

1984-1996 Chief, Preventive Medicine Services, US Army Community Hospital, Fort Dix, NJ

Postdoctoral Training

1981-1982 Intership Family Practice, Womack Army Community Hospital, Fort Bragg, NC

1982-1984 Residency in General Preventive Medicine/Public Health, Walter Reed Army Medical Center/Water Reed Army Institute of Research, Washington, DC

Selected Committees

1998-1999 Scientific Advisory Board, American Foundation for AIDS Research (AmFar)

1998-1999 AIDS Vaccine Working Group on the US Public Health Service

1998-1999 NIH Selection Committee for HIV Vaccine Trials Network (HVTN) Leadership Group

1998-1999 Consultant, Center for Public Helath Research, Research Institute for Health Sciences, Chiang Mai University, Chiang Mai, Thailand

1998-1999 Consultant, UNAIDS HIV Vaccine Workshop, Tokyo, Japan

1998-1999 Consultant, Harvard AIDS Institute Workshop on HIV Vaccines, Dakar, Senegal

1998-1999 Director, Military Benefits Association

DEBORAH L. BIRX

8505 White Post Court
Potomac,MD 20854

Education

Medical School:	Pennsylvania State University Hershey Medical School Hershey, Pennsylvania	January, 1980
	M.D.	
College:	Houghton College B.S., summa cum laude	1976

Training:

Fellowship:	Allergy/Clinical Immunology Walter Reed Army Medical Center	1983 -1985
Residency:	Internal Medicine Walter Reed Army Medical Center	1981 -1983
Internship:	Categorical Medicine Walter Reed Army Medical Center	1980 -1981

Employment:

Director Division of Retrovirology Walter Reed Army Institute of Research	1996 -present
Laboratory Director HIV-1 Vaccine Development Walter Reed Army Institute of Research	1995 -1996
Chief Department of Retroviral Research Walter Reed Army Institute of Research	1994-1995
Consultant, Allergy Immunology-Svc	1989 -present
Assistant Chief Department of Retroviral Research Walter Reed Army Institute of Research	1989 -1994
Investigator, Cellular Immunology	1986 -1989
Assistant Chief Allergy /Immunology Service Walter Reed Army Medical Center	1985-19S9

Faculty Appointment:

Assistant Professor of Pediatrics Uniformed Services University of the Health Sciences	1986 -present
Assistant Professor of Medicine Uniformed Services University of the Health Sciences	1985 -present
Teaching Fellow Uniformed Services University of the Health Sciences	1980 -1985

Reviewer:

Journal of AIDS
AIDS and Human Retroviruses
AIDS
Clinical Infectious Diseases
Journal of Infectious Disease
AAAI National Mtg. -Basic/Clinical Immunology

Grant Reviewer:

Vaccine Trials Network -1999
CFAR-1998
NCVDG -1997
SPIRAT -1995
VACCINE PREPAREDNESS SITES -1994
SPIRAT -1994
NCVDG -1993

Research Interests:

Immunology of HIV : Analysis and description of function of T and B cell specific responses

HIV Vaccine development

Immunoregulation of viral infections

B cell dysfunction in AIDS/ARC patients

EBV infection and immunoregulation in man

Cation effect on lymphocyte activation.

K.M. SHYAMPRASAD

Qualifications :

Member National Academy of Medical Sciences. (General Surgery)
M.Ch. (Cardiothoracic Surgery)

Fellow of the Indian Association of Cardiovascular - Thoracic Surgeons.

Speciality :

Cardiothoracic Surgery and Hospital Administration.

Present Positions : Director, C.S.I. Rainy Multi-Speciality Hospital, Chennai - 600 021.

Chairman, Christian Medical College, Ludhiana, Pujab.

Member, Governing Board, National Board of Examinations. New Delhi

Past Positions:

Reader in Cardiothoracic Surgery, Christian Medical College, Vellore

Associate Editor, Indian Journal of Thoracic and Cardiovascular Surgery

Graduate Training:

Christian Medical College, Vellore

Post-Graduate Training : Government General Hospital and Madras Medical College, Chennai

Super-Speciality Training : Government General Hospital and Mardras Medical College, Chennai

Higher Training and Research: University Hospital, Zurich, Switzerland.

Special interests:

Post-graduate surgical training Medical Education reforms
Ethical medical practice Research.

Published more than 15 papers.

LIST OF PARTICIPANTS

Dr. ANDREI P KOZLOV
7,PUDOZHSKAJA
RUSSIA,

ANTON POZNIAK
CHELSEA & WEST MINISTER HEALTH
CARE NHS TRUST,
ST.STENHEN'S CENTRE
LONDON SW 10 9TH
UK

CARL-HENIZ POMMER
BOEHRINGER INGELHEIM GMBH
CORPORATE DIVISION HOSPITAL,
BINGER STRASSE 173,
D-55216 INGELHEIM AM RHEIN
GERMANY

Dr. CATHERINE PECKHAM
INSTITUTE OF CHILD HEALTH,
PEADIATRIC EPIDEMIOLOGY DEPT,
30 GUIL FORD STREET,
WCIN 1EH LONDON
UK

Dr. CECILIO LOPEZ GALINDEZ
CTRA.MAJADAHONDA-POZUELO KM.2
28220 MAJADAHONDA
MADRID
SPAIN

Dr. CIPRIANO CANOSA
HOSPITAL CASA DE
LA SALUD-DPTO.PEDIATRIA,
MANUAL CANDALA 41 46021
VALENCIA
SPAIN

CONSTANCE BLOWERES
GLAXO WELLCOME
NORTH CAROLINA
USA

Dr. DEBORAH BIRX
DIRECTOR,DEVELOPMENT PROGRAMME
WALTER REED ARMY INSTITUTE OF RESEARCH,
SUITE 250,ONE TAFT COURT,
ROCKVILLE,MD
USA

9 Dr. DONALD E MESSER
PRESIDENT ILIFF SCHOOL OF THEOLOGY,
2201,S UNIVERSITY BL VD
DENVER COLORADO
USA

10 Dr. DOROTHY BRAY
SENIOR CLINICAL PROGRAM HEAD
THERAPEUTIC DEVELOPMENT GROUP,
GLAXO WELCOME R&D,GREENFORD ROAD,
GREENFORD MIDDLESEX,UB 60 HE
UK

11 Dr. GRACE JOHN
UNIVERSITY OF WASHINGTON,INTERNATIONAL AIDS RESEARCH
AND TRAINING PROGRAMME,
BOX 359909-325-9TH AVENUE,
WA 98104-2499,SEATTLE
USA

12 Dr. HANS JAGER
INTERNIST
KARLS PLATS(STACHUS) 8
80336 MUNCHEN,
GERMANY

13 Dr. INDIRA K.HEWLETT
CHIEF LAB.OF MOLECULAR VIROLOGY
DIVISION OF TRANSFUSION TRANSMITTED DISEASES
1401,ROCKVILLE PIKE,
ROCKVILLE MD
USA

14 JOEP LANGE
PROF.OF MEDICINE,
ACADEMIC MEDICAL CENTRE,
UNIV.OF AMSTERDARM,MEIBERGDREEF 9
1005 AZ AMSTERDARM
THE NETHERLANDS

15 Dr. JORETT MARSHALL
ILIFF SCHOOL OF THEOLOGY
2201,S UNIVERSITY BL VD
DENVER COLORADO
USA

16 Dr. JULIE MCELRATH
UNIVERSITY OF WASHINGTON
FRED NUTCHINSAN CANCER RESEARCH CENTRE
1100 FAIRVIEW AVENUE,
NORTH D3100,SEATTLE KIA
USA

17 KATE
SENIOR SCIENTIST,NATIONAL SEROLOGY REFERENCE LAB,
NRL 4TH FLOOR,
HEALY WING 41 VICTORIA PRADE,
FITZROY VIC 3065
AUSTRILLA

18 Dr. KOEN VAN ROMPAY
CALIFORNIA REGIONAL PRIMATE CENTER
UNIVERSITY OF CALIFORNIA,
COUNT ROAD 98 HUTCHISON,
DAVIS CA 95616,
USA

19 Dr. LARS O.KALLINGS
SECRETARY GENERAL,
INTERNATIONAL AIDS SOCIETY,
P.O.BOX NO:5619
SE-114 86 STOCKHOLM,
SWEDEN

20 Dr. MAHAJAN.P
ASSOCIATE DIRECTOR,GLAXO WELCOME
INC,FIVE MOORE DRIVE,
RESEARCH TRIANGLE PARK,
NORTH CAROLINA 27709-3398
USA

21 Dr. MARK MIROCHNICK
DEPT.OF PEDIAATRICS
BOSTON UNIVERSITY,
BOSTON MA,
USA

22 Dr. MARK WAINBERG
MCGILL AIDS CENTRE
JEWISH GENERAL HOSPITAL,
3755 CHEMIN COTE'STE
ST.CATHERINE,MONTERAL,QUEBEC
CANADA H3 T IE2

23 Dr. MILTON R TAM
TECHNICAL DIRETOR ,
PATH,4 NICKERSONS STREET
SEATTLE,WA 98109
USA

24 Dr. NAFEES AHMED
ASSOCIATES PROF.MICROBIOLOGY & IMMUNOLOGY
COLLEGE OF MEDICINE,
UNIVERSITY OF ARIZONA,
TUCSON,AZ 85724
USA

25 Dr. NEIL CONSTANTINE
DIRECTOR-CLINICAL IMMUNOLOGY,UNIVERSIT
MD MED.SYSTEM,INSTITUTE OF
HUMAN VIROLOGY, RM515,725 W
LOMBARD STREET,BALTIMORE,MARYLAND,2120
USA

26 Dr. PETER N.MUGYENYI

UGANDA
SOUTH AFRICA

27 Dr. RICHARD POTMAN
HAARLEMMER HOUTTUINEN 45 D
1013 GM AMSTERDAM
THE NETHERLANDS

28 Dr. ROGER P BERNARD
DIRECTOR AIDS FEEDBACK
FIELD EPIDEMIOLOGY & LIAISON OFFICE
22,AVENUE RIAND-PARC 1209 GENEVA
SWITZERLAND

29 Dr. SAI SUBHASREE RAGHAVAN
ASST.PROF.CLINICAL NUTRITION MEDICINE,
COLUMBIA UNIVERSITY,
900 WEST, 190TH STREET #15B,
NEW YORK
USA

30 Dr. SAVITHA PAHWA
CHIEF DIVISION OF PEDIATRIC,
NORTH SHORE UNIVERSITY HOSPITAL,
NEW YORK UNIVERSITY SCHOOL OF MEDICINE
350,COMMUNITY DRIVE,MANHASSET NY,
USA

31 Dr. STEFANO VELLA
INTITU SUPERIORE DI SANITA
VIALE REGINA ELENA
299-00161,ROME
ITALY

32 Dr. SUE BEST
SENIOR SCIENTIST,NATIONAL SEROLOGY REF
NRL 4TH FLOOR,
HEALY WING 41 VICTORIA PRADE,
FITZROY VIC 3065
AUSTRILLA

33 Dr. URSULA DIETRICH
GEORGE-SPEYER-HAUS,
PAUL-EHRLICH-STR,42-44
D-60597 FRANKFURT
GERMANY

34 Dr. YASHMIN HELLIMA
AUF DER HEIDE 107
58313 HERDECKE
GERMANY

ABDUL RAHIM
AI,124,8TH MAIN ROAD,
SHANTI COLONY,
CHENNAI 600 040
TAMIL NADU
INDIA

Dr. ABRAHAM.O.C
MEDICAL UNIT I CHIEF,
CMC,VELLORE
TAMIL NADU
INDIA

Dr. ALKA DESHPANDE
A/8 SRISAHAWAS
GHAT KOPAR EAST
MUMBAI 400 077
INDIA

ALLAUDIN.K
PROJECT DIRECTOR,
TN STATE AIDS CONTROL SOCIETY,
417 PANTHEON ROAD,EGMORE,CHENNAI
TAMIL NADU
INDIA

AMANDA MURPHY
TEDDY TRUST,TENKASI ROAD,
ALAMPATTI POST,
THIRUMANGALAM,MADURAI DIST 625 706
TAMIL NADU
INDIA

Dr. ANAND GROVER
JALARAM JYOT,4TH FLOOR,
63,JANMA BOOMI MARG,
FORT,
MUMBAI 400 001
INDIA

Dr. ANAND KUMAR
22,RAGAVIAH ROAD,
T.NAGAR,
CHENNAI 600 017,
TAMIL NADU
INDIA

8 ANJALI GOPALAN
EXECUTIVE DIRECTOR,NAZ FOUNDATION TRUST,
P.O.BOX 3910,ANDREWS GUNJ,
NEW DELHI 110 049
INDIA

9 Dr. ARTHI.S
4,RAGHAVEERA AVENUE,
POES GARDEN,
CHENNAI 600 086
TAMIL NADU
INDIA

10 ASHOK PILLAI
INP+
29/2 VELU STREET,
WEST MAMBALAM,CHENNAI-33
TAMIL NADU
INDIA

11 Dr. ATUL PATEL.K
41,SUNDERVAN TWIN BANGLOWS
VASTRAPUR
AHMEDABAD 380 015
INDIA

12 BALASUBRAMANIAN
PROJECT DIRECTOR,
PONDICHERRY AIDS CONTROL SOCIETY,
ODEAN SALAI,ANNA SQUARE,PONDICHERRY 605 001
TAMIL NADU
INDIA

13 BANERJEE.K.L
ASSOCIATE PROF. STATE PRAM,
FE-97 SECTOR 3,
SALT LAKE CITY,
CALCUTTA 700 051
INDIA

14 Dr. CHANDRASEKHARAN
MEDICAL ADVISOR,GLAXO INDIA LTD,
DR.ANNE BESANT ROAD,
MUMBAI 400 025
INDIA

15 Dr. CN DEIVANAYAGAM FRCP(EDIN)
SUPERINDENT,
GOVERNMENT HOSPITAL OF THORACIC MEDICINE
TAMBARAM,CHENNAI 600 047
TAMIL NADU
INDIA

16 Dr. DOLLY ROSE
DEPT.OF CLINICAL PATHOLOGY,
BLOOD BANK,
CMC,VELLORE 632 004
TAMIL NADU
INDIA

17 Dr. GANESH
4/51,NAKINAR STREET,
KURINJI NAGAR,
NARAYANAPURAM,MADURAI -14
TAMIL NADU
INDIA

18 Dr. GANGA KHEDKAR
SR.RESEARCH MEDICAL OFFICER,NARI,
IGMR,PLOT NO.73,
G BLOCK MIDC,BHOSARI,
PUNE 411 026
INDIA

19 Dr. GEORGE CHANDY
PROF. & HEAD,
CLINICAL GASTROENTEROLOGY & HEPATOLOGY UNIT,
DEPT.OF GI SCIENCE,CMC & HOSPITAL,VELLORE,
TAMIL NADU
INDIA

20 Dr. GILADA.I.S
SECRETARY GENERAL.IHO,
MUNICIPAL SCHOOL BUILDING,
J-J HOSPITAL COMPOUND,
MUMBAI 400 008
INDIA

21 GNANA SWARPANANDA
RAMKRISHNA MISSION VIDYALAYA,
PERIYANAYA PALAYAM
COIMBATORE 641 020
TAMIL NADU
INDIA

22 Dr. GOURI DEVI.M
DIRECTOR ,PROF.OF NEUROLOGY
NIMHANS
BANGALORE
INDIA

23 ISHWAR VISWESHWAR
PLOT.3045,5TH STREET,
13TH MAIN ROAD,
ANNA NAGAR 600 040
INDIA

24 Dr. JACOB JOHN.T
2/91,E2
KAMALAKSHIPURAM
VELLORE
INDIA

25 Dr. JAJU
PROF.OF PEDIATRICS,
ACHARYA DONDI MARG,
PAREL,
MUMBAI 400 012
INDIA

26 Dr. JAWAHAR
DEAN,PSG MEDICAL COLLEGE,
COIMBATORE
INDIA

27 Dr. JAYAPRAKASH NARAYARAN
PROF & HOD-SPECIAL MEDICINE,
GOVT. SIDDHA MEDICAL COLLEGE
CHENNAI 600 106
INDIA

28 Dr. JERAJANI.RN
PROF. & HEAD,
DEPT.OF DERMATOLOGY,LTM MED
COLLEGE & LTM GENERAL HOSPIT
SION,MUMBAI 400 022
INDIA

29 Dr. JEYAKAR PAUL
28,SBI OFFICERS COLONY
P.H.ROAD,ARUMBAKKAM,
CHENNAI
INDIA

N KR
LTH ECONOMIST,
T. COMMUNITY MEDICINE,
D,
GAYAM,VELLORE
A

N PC
T BOX 1404,
NNAI
A

JOSHI
IONAL AIDS CONTROL,
ISTRY OF HEALTH & FAMILY WELFARE,
M NO.523,NIRMAN BHAWAN,
DELHI 110 011
A

JYOTIMAY BISWAS
KARA NETHRALAYA
OLLEGE ROAD
NNAI 600 006
IA

MAL SHERIFF
ECTOR PUBLIC HEALTH &
VENTIVE MEDICINE,
S CAMPUS,
ENNAI 600 018
IA

KESAVAN.M
AD AMALA AYURVEDIC
EARCH CENTRE,
CHUR 680 553
RALA
IA

. KRISHNAMURTHY.P(SPONS)
S PREVENTION AND CONTROL PROJECT,
LUNTARY HEALTH SERVICES,
TI POST,ADYAR,
ENNAI
IA

37 Dr. MANIAR.J.K
69/2 WALKESHWAR ROAD,
MUMBAI 400 006
INDIA

38 Dr. MANJULLA DUTTA
PROF. & HOD,
DEPT. OF EPIDEMIOLOGY,
THE TN Dr.M.G.R. MEDICAL UNIVERSITY,
GUINDY,CHENNAI - 600 032,
INDIA

39 Dr. MANOHARAN.G
PROF & HOD,DEPT OF MEDICINE,
PERUNDURAI MEDICAL COLLEGE,
PERUNDURAI SANATORIUM,
PERIYAR DIST,TAMIL NADU
INDIA

40 Dr. MANORAMA.P
RASI HOSPITAL,
102A RANGARAJAPURAM MAIN ROAD,
KODABAKKAM,
CHENNAI 600 024
INDIA

41 MATHAI MATHEW
PROF. & HEAD,
DEPT. OF OBS & GYNAEC
CMC,VELLORE
INDIA

42 MATHEW N.G
ST.GEORGE'S CATHEDRAL
2/24 CATHEDRAL ROAD,
CHENNAI 600 086
INDIA

43 Dr. MERCHANT RH
DEAN & PROF.OF PAEDIATRICS,
DIRECTOR,PERINATAL & HIV PROGRAM,
BAI JERBAI,HOSPITAL FOR CHILDREN,
ACHARYA DHANDE MARG,PAREL MUMBAI-12
INDIA

44 Dr. MINI JACOB
DEPT.OF EXPERIMENTAL MEDICINE,
THE TN M.G.R MEDICAL UNIVERSITY
GUINDY,
CHENNAI 600 032
INDIA

45 Dr. MRIDULA PHADKE
DEAN & DIRECTOR,
ICMR PROJECT, BJ MEDICAL COLLEGE
& SASSON GENERAL HOSPITAL,
PUNE
INDIA

46 Dr. MURALI NHS(SPONS)
APAC PROJECT,VHS
TTTI POST
ADYAR,CHENNAI
TAMIL NADU
INDIA

47 Dr. NALINI RAMAMURTHY
HOD-DEPT OF VIROLOGY,
KING INSTITUTE,
GUINDY,CHENNAI 600 032
TAMIL NADU
INDIA

48 NARAYANAN
TRC
TAMIL NADU
INDIA

49 Dr. PARAMESHWARI
DEPT.OF EXPERIMENTAL MEDICINE,
THE TN.M.G.R MEDICAL UNIVERSITY,
GUINDY,CHENNAI 600 032
TAMIL NADU
INDIA

50 PHADTARE.J
A/2 GOODWILL ASSURANCE BUILDING,
MAN MALA TANK ROAD,
MAHIM
MUMBAI 400 016
INDIA

51 Dr. PRADEEP SETH
PROF & HEAD OF MICROBIOLOGY
ALL INDIA INST. OF MEDICAL SCIENCES
ANSARI NAGAR,
NEW DELHI
INDIA

52 PRASAD RAO JVR
NATIONAL AIDS CONTROL ORGANISATIO
MINISTRY OF HEALTH & FAMILY WELFAR
INDIAN RED CROSS BUILDING,NIRMAN BH
NEW DELHI
INDIA

53 Dr. PRATHAP THARIYAN
DIRECTOR,
MENTAL HEALTH CENTRE,
BAGAYAM, CMC,VELLORE
TAMIL NADU
INDIA

54 Dr. RADHAKRISHNAN.K.M
DEPT.OF TRANSFUSION MEDICINE,
THE TN Dr.M.G.R.MEDICAL UNIVERSITY,
GUINDY,CHENNAI 600 032
TAMIL NADU
INDIA

55 Dr. RAJASEKARAN.S
PROF.OF THORACIC MEDICINE,
GOVT.RAJA MIRASUDAR HOSPITAL,
THANJAVUR 613 001
TAMIL NADU
INDIA

56 Dr. RAJKUMAR
47/3 NEW AVADI ROAD,
KILPAUK,
CHENNAI 600 010
TAMIL NADU
INDIA

RAMASUBRAMANIAN.V
T.OF STD,
RAMACHANDRA MEDICAL
LEGE & HOSPITAL,PORUR,CHENNAI
IL NADU
A

RAMESH S PARANJAPE
UTY DIRECTOR,
I,PLOT NO.73,G BLOCK MIDC,
SARI,PUNE 411 026
IARASTRA
A

RANGA BHASHYAM
E RAMANA SURGICAL CLINIC,
ENKATA NARAYANA ROAD,
AGAR,CHENNAI 600 017
IIL NADU
A

VI JACOB KORULLA
NCIPAL,
ISTIAN MEDICAL COLLEGE,
RAPADI,POST,VELLORE 632 002
IIL NADU
IA

REMA MENON
DICAL OFFICER,
VOLUNTARY DONOR BLOOD BANK,
HOUSE,WARRIAM ROAD,COCHIN 682 016
ALA
IA

SAMUEL.N.M
OF. & HEAD,DEPT.OF EXPERIMENTAL
DICINE,THE TN M.G.R MEDICAL UNIVERSITY,
NDY,CHENNAI 600 032
MIL NADU
IA

SANJAY PUJARI
0 SADSHIV PETH,
RAM SHAM APTS
NE 411 030
HARASTRA
IA

64 Dr. SANKARAN JR
C-1,ASHOK AKSHARA
NO.21 VALLIAMMAL STREET,
KILPAUK,CHENNAI
TAMIL NADU
INDIA

65 Dr. SAPLE DG
534 BOMBAY MUTUAL TERRACE
2nd FLOOR, SANDHURST BRIDGE,
ABONE BOMBAY MOTOR CYCLE,OPERA HOURSE
MUMBAI
INDIA

66 Dr. SARASWATHI SANKARAN
DESH 3 D'MONTE COLONY,
TTK ROAD,
ALWARPET,CHENNAI 600 018
TAMIL NADU
INDIA

67 Dr. SATHYANATHAN.R
DIRECTOR,
CLINICAL EPIDEMIOLOGY UNIT,
CMC,CHENNAI 600 003
TAMIL NADU
INDIA

68 Dr. SHEILA SHYAMPRASAD
CSI RAINY MULTI SPECIALITY HOSPITAL,
45,GA ROAD,ROYAPURAM
CHENNAI 21
TAMIL NADU
INDIA

69 Dr. SHOBA SEHGAL
PROF.& HOD,DEPT.OF IMMUNOPATHLOGY,
PG INSTITUTE OF MEDICAL EDUCATION & RESEARCH
CHANDIGARH
PUNJAB
INDIA

70 Dr. SHRIDHARAN G
PROF.& HOD,DEPT. OF CLINICAL VIROLOGY,
CM COLLEGE AND HOSPITAL,
IDA SCUDDER ROAD,PO BOX-3,VELLORE
TAMIL NADU
INDIA

71 SIVASANKARI
7,FIRST LINK STREET,
KARAPAGAM GARDEN,
CHENNAI 600 020
TAMIL NADU
INDIA

72 SOUNDARA PANDIAN
CONSULTANT,UNIT OF HIV MEDICINE,
MEENAKSHI MISSION HOSPITAL &
RESEARCH UNITS,LAKE AREA,MELUR ROAD.
MADURAI 625 107
TAMIL NADU
INDIA

73 Dr. SRIKANTH TRIPATHY
NARI,INDIAN COUNCIL OF MEDICAL RESEARCH,
PLOT.NO.73 'G' BLOCK
MIDC-BHOSARI
PUNE 411026
INDIA

74 Dr. SUBHASH HIRA
502,DEBONAR APARTMENT,
CADELL ROAD,
MAHIM WEST,
MUMBAI 400 016
INDIA

75 Dr. SUDHAKAR
PROJECT OFFICER,US AGENCY FOR INTERNATIONAL
DEVELOPMENT,B-28 INSTITUTIONAL AREA,
QUTAB HOTEL ROAD,
NEW DELHI
INDIA

76 Dr. SURESH KUMAR
NO.12 VAIDYARAM STREET,
T.NAGAR
CHENNAI -17
TAMIL NADU
INDIA

77 Dr. SURESH.B
PRINCIPAL,JSS COLLEGE OF
PHARAMACY,BOMBAY CASTLE,
ELKILL ROAD,UDAGAMANDALAM,NI
TAMIL NADU
INDIA

78 Dr. UZGARE.R.H
ADVANI APARTMENTS, FLAT NO.2,
NEAR DEEP MANDIR CINEMA,
LAL BAHADUR SASTRI MARG,
MUMBAI 400 080
INDIA

79 VIJAYA KUMAR
NEPHROLOGIST,CHENNAI KALLIAPPA
HOSPITAL,43-SECOND MAIN ROAD,
RAJA ANNAMALAI PURAM,CHENNAI 6
TAMIL NADU
INDIA

80 VIJAYLAKSHMI ACHARYA
8B THIRUMOORTHY NAGAR,
VI STREET,
NUNGAMBAKKAM,CHENNAI 600 032
TAMIL NADU
INDIA

81 Dr. VIMALA RAMALINGAM
10,WADDELS ROAD,
KILPAUK,
CHENNAI 600 010
TAMIL NADU
INDIA

82 Dr. VINAYAK
DEPT.OF BIOTECHNOLOGY,MINISTRY
& TECHNOLOGY,BLOCK-2 (7TH-8TH FL
CGO COMPLEX,LODI ROAD,
NEW DELHI 110 003
INDIA

1 ABHISHEGNATHAN.R
S/o ROBERT,
H/F 172A RAILWAY QUARTERS,
ARAKKONAM
VELLORE DISTRICT
INDIA

2 ABRAHAM.K.K
29/2,VELU STREET,
WEST MAMBALAM,
CHENNAI 600 033
INDIA

3 Dr. AFZAR (SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

4 ALAGAPPAN.R
KMCH COLLEGE OF PHARMACY,
PO BOX 32009,
COIMBATORE
INDIA

5 ALAMELU
DEPT. OF EXPERIMENTAL
MEDICINE,
THE TN Dr.M.G.R. MEDICAL
UNIVERSITY,GUINDY 32
INDIA

6 Dr. ALGOTHAR
ASST.PROF
DEPT. OF OB & G,
JJ HOSPITAL & GRANDS
MEDICAL COLLEGE,MUMBAI
INDIA

7 Dr. AMALA GEORGE
SANKARA NETHRALAYA
18 COLLEGE ROAD,
CHENNAI 600 006
INDIA

8 AMALAHAZEL
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

9 AMBIGA CHORANUR (APAC)
OSMANIA MEDICAL COLLEGE,
GOVT.MATERNITY HOSPITAL,
HYDERABAD,
INDIA

10 Dr. AMEER JAHAN.A
SUBAITHA CLINIC
37 HARRIS ROAD PUDUPET,
CHENNAI-2
INDIA

11 AMUDHA.N
GOVT.GEN.HOSPITAL,
14TH WARD,
STD DEPT,
CHENNAI - 3
INDIA

12 AMUTHAMEENA.G.S
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

13 ANAND KUMAR(APAC)
SPECIALIST CONDOM PROMOTION
INDIA

14 ANANDHI.Y
NO.23 BRINDAVAN STREET,
WEST MAMBALAM,
CHENNAI 33
INDIA

15 Dr. ANARA SAMBIN RAO
GUNTUR DOCTOR XRAY INST(P) LTD,
BHAGAT SINGH CENTRE KOLHAPT,
GUNTUR 522 001
INDIA

16 ANBAZHAGAN.S
GOVERNMENT SIDDHA COLLEGE,
PALAYAMKOTTAI
MEN'S HOSTEL,VANNARAPET
TIRUNELVELI
INDIA

17 Dr. ANBU.N
POST GRADUATE STUDENT'S ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

18 ANBUKUMAR
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

19 ANCY PHILIP
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

20 ANDI EICHER
DISHA CH PROJECT,
NAV JEEVAN HOSPITAL,
POSTHARWA,PALAMU DIST,
BIHAR 822 126
INDIA

21 ANGAYARKANNI
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

22 ANGELA GANADURAI
ASSOCIATE PROF.OF NURSING
COLLEGE OF NURSING
CHRISTIAN MEDICAL COLLEGE
& HOSPITAL,VELLORE 632 004
INDIA

23 Dr. ANIL CHERIAN
UTAULA RCH PROJECT,
PREM SEWA HOSPITAL,
PO UTRAULA,BARAMPUR DIST
UP 271 601
INDIA

24 ANNADURAI.P
GOVT SIDDHA MEDICAL COLL
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

25 Dr. ANNAM SURESH

26 Dr. ANNE PAUL
CHRISTIAN MEDICAL COLLEG
DEPT. OF COMMUNITY MEDIC
CHAD,BAGAYAM
VELLORE
INDIA

27 ANNSPEIRS (SIAAP)

28 ARASU.K.T (APCA)
ALTERNATIVE FOR INDIA DE
TVGN NAGAR,
IYYAPANTHANGAL,KATTUPAKK
CHENNAI 56
INDIA

29 ARATHI
GOVT SIDDHA MEDICAL COLL
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

30 Dr. ARATHI.M.P MACOG
NO.4 RAGAVEERA AVENUE,
POES GARDEN
CHENNAI 600 086
INDIA

. ARCHANA SHAHAPURKAR
ECTURER
EPT. OF MEDICINE,
J HOSPITAL & GRANDS
EDICAL COLLEGE,MUMBAI
NDIA

RJUN DEV CHADHA
/O IS GILADA,
NDIAN HEALTH ORGANISATION,
UMBAI
NDIA

RUL RAJ LOUIS(APAC)
PARKRITI' 6,
AGANATHAN RAOD,
UNGAMBAKKAM,
HENNAI 600 034
NDIA

RUL.V
EPT.OF PHARMACOLOGY & ENVIRONMENT
OXICOLOGY,Dr.A.L.M.P.G
NSTITUTE OF BASIC MEDICAL SCIENCES,
ARAMANI,CHENNAI 113
NDIA

RUN.M
OVERNMENT SIDDHA MEDICAL COLLEGE
ALAYAMKOT
IRUNELVELI
NDIA

RUNA AKKIREDDI(AUS)

SHA BANU.S.L
HE MADRAS SCHOOL OF SOCIAL WORK,
2 CASA MAJOR ROAD,
GMORE,
HENNAI 600 008
NDIA

r. ASHA RAO (SR)
OMMUNITY ACTION TRUST
Ist FLOOR 4th STREET,
ADMANABHA NAGAR,ADYAR
HENNAI 600 020
NDIA

39 Dr. ASHOK KUMAR.K
ST.LUKES HIV/AIDS RESEARCH
CARE CENTRE,
GUDIVADA ROAD,
HANUMAN JUNCTION,
ANDHRA PRADESH 521 105
INDIA

40 ASHWIN KUMAR.R
P.NO.34,2nd CROSS STREET,
SENTHIL NAGAR,
KALATHUR,
INDIA

41 AUGUSTINE(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

42 AYISHA
DEPT. OF EXPERIMENTAL
MEDICINE,
THE TN Dr.M.G.R. MEDICAL
UNIVERSITY,GUINDY 32
INDIA

43 AYYADURAI.S
KMCH COLLEGE OF PHARMACY,
P.O.BOX 3209
COIMBATORE
INDIA

44 BABU JACOB
AMALA HOSPITAL,
ANAIMALAYANPATTY 625 526
INDIA

45 Dr. BABY
MEDICAL OFFICER,SOCIETY FOR
HIV/AIDS & LIFE LIVE OPERATION
IN MANIPUR,NEHRU MARG,
CHURATCHANDPUR,MANIPUR 795 128
INDIA

46 BAKTHAVATSALAM.D
HEAD MASTER,
PUE SCHOOL,
PALAKKARANOOR
AROORPATTI 636 502
INDIA

47 Dr. BALAKRISHNAN.A (APAC)
PROJECT CO-ORDINATOR,
74,ARCOT ROAD,
VADAPALANI,
CHENNAI 600 026
INDIA

48 Dr. BALASUBRAMANIAN.D
PROJECT DIRECTOR,
PONDICHERRY AIDS CONTROL SOCIETY,
JEAN MERMOZ PHC CAMPUS,
ODIAN SALAI,PONDICHERRY 605 001
INDIA

49 Dr. BANU MURTHY.K
NO.32 CHELLA PERUMAL ST,
BHARATHI NAGAR,
THIRUVANMIYUR,
CHENNAI 600 041

50 Dr. BERYL PRIMROSE
CHRISTIAN MEDICAL COLLEGE,
DEPT. OF COMMUNITY MEDICINE,
CHAD,BHAGAYAM
VELLORE,
INDIA

51 Dr. BETHSEEBA
CHAMPA CHRISTIAN HOSPITAL,
PO CHAMPA
MP 495671
INDIA

52 BEVERLEY SNELL(AUS)

53 BHAGAWANDAS(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

54 Dr. BHAGEERATHI.P
NO.5045,'H'BLOCK,
25th STREET,PONNI COLONY,
ANNA NAGAR WEST,
CHENNAI 40
INDIA

55 BHARATHAN.R
GOVERNMENT SIDDHA COLLEGE
PALAYAMKOTTAI
MEN'S HOSTEL,VANNARAPET
TIRUNELVELI
INDIA

56 BHARATHI.K
GOVERNMENT SIDDHA COLLEGE
PALAYAMKOTTAI
MEN'S HOSTEL,VANNARAPET
TIRUNELVELI
INDIA

57 Dr. BHUVANESWARI.S
INSTITUTE OF VENERAOLOGY,
GOVT. GENERAL HOSPITAL,
CHENNAI 3
INDIA

58 BIJU RAMACHANDRAN
MSC(N) IIYR SACRED HEART
COLLEGE,
MADURAI-20
TAMIL NADU
INDIA

59 Dr. BIMAL CHARLES (SPONS)
ASST. DIRECTOR-NGO PROGRA
APAC,
VOLUNTARY HEALTH SERVICE,
ADYAR,CHENNAI
INDIA

Dr. BIRUNDA DEVI.M
S/O THANGAIAH
54 PERUMAL EAST CAR STREET,
PALAYAMKOTTAI,
TIRUNELVELI 627 002
INDIA

BLESSY RACHEL SAMUEL
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

Dr. BOSCO.B
CITY HOSPITAL,
14 RAJA COLONY,
CANTONMENT
TRICHY 620 018
INDIA

Dr. BRIDGET AKILA
CHRISTIAN MEDICAL COLLEGE,
DEPT. OF COMMUNITY MEDICINE,
CHAD,BHAGAYAM
VELLORE,
INDIA

CHANDRA SINGH
TUTOR,NURSING SCHOOL,
NAV JEEVAN HOSPITAL,
PO SATBARWA,PALAMU DIST,
BIHAR 822 126
INDIA

Dr. CHANDRASEKAR.S
POST GRADUATE STUDENT'S
ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

Dr. CHANDRASEKARAN

67 Dr. CHANDRASEKARAN.T
M/S TN COLLEGE OF NATUROPATHY &
YOGI SCIENCE
342-A TRICHY MAIN ROAD
SALEM
INDIA

68 CHARA RAPHAEL
WORLD VISION OF INDIA
14 SHANMUGARYAN STREET,
PURSAIWALKAM,
CHENNAI 600 007
INDIA

69 Dr. CHIRANJEEB KAKOTY
DIRECTOR,NORTH EAST SOCIETY
FOR THE PROMOTION OF YOUTH
AND MASSES,ASHRAM ROAD,NEW
WATER TANKS ULUBARI,GUWAHATI 781 007
INDIA

70 CHITRA.B
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

71 CHITRA.S
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

72 CHITRA.T
GOVT SIDDHA MEDICAL COLLEGE,
PALAYAMKOTTAI,
LADIES HOSTEL,
TIRUNELVELI 627 002
INDIA

73 Dr. CHRISTOPHER DANIEL.J
NO.5,SOUTH STREET EXTN,
SINGARAYAR COLONY,
MADURAI
INDIA

74 CHRISTOPHER S.BASKERAN
WORLD VISION OF INDIA
14 SHANMUGARYAN STREET,
PURSAIWALKAM,
CHENNAI 600 007
INDIA

75 CLARE STAINSBY(AUS)

76 COLLEN ROLLS(AUS)

77 Dr. DAISY DHARMARAJ
NO:4 SATHALVAR STREET,
MOGAPPAIR WEST
CHENNAI
INDIA

78 Dr. DAIZY RANI
4/124 THIRVENI NAGAR,
NAGAMALAI PUDUKKOTTAI,
MADURAI 19
INDIA

79 DAVID THIYAGARAJAN.D(APAC)
IMAGE MADURAI
INDIA

80 DEEPA THAMPI
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM
ERODE
INDIA

81 DEVAASIRVATHAM.I.D
85,KAVANOOR VILLAGE POST,
ARAKONAM TAULK 631 002,
VELLORE DISTRICT
TAMIL NADU
INDIA

82 DEVAN.K
DEPT.OF NSS & ADULT EDUCATION,
PONDICHERRY UNIVERSITY,
PONDICHERRY
INDIA

83 DHANALAKSHMI.G
102-A,RANGARAJAPURAM MAIN ROA
KODABAKKAM,
CHENNAI
INDIA

84 DHANAM.R
POSITIVE WOMEN'S NETWORK
NAMAKKAL
INDIA

85 DHANDAPANI

86 DIANA REES(AUS)

87 DIRAVIARAJ

88 DOLLY PREMILA.M
8-S7,BEHIND SONA MINA THEATRE
WILLIAMS RAOD,CANTONMENT,
TRICHY 1
TAMIL NADU
INDIA

89 DONGAONKAR (ARCON)
BYLNAIR MEDICAL COLLEGE,
GYNEACOLOGY - NAIR MEDICAL CO
MUMBAI CENTRAL,
MUMBAI
INDIA

90 EDWARD UDHAYARAJ.S
EDAYAKUPPAM,
KOKKERI(PO) VIA,
MELPADI 632 520
INDIA

91 EDWIN AMALRAJ
DEPT.OF EPIDEMIOLOGY,
THE TN Dr.M.G.R MEDICAL
UNIVERSITY,GUINDY
CHENNAI
INDIA

EDWIN GEORGE
CHIEF SECRETARY,
TERRITORIAL HEAD QUARTERS,
PO BOX 802 KOWDIA P.O
TRIVANDRUM,KERALA
INDIA

Dr. EDWIN STEPHEN
RUSHA DEPT,CHRISTIAN MEDICAL
COLLEGE & HOSPITAL,
RUSHA CAMPUS PO 632 209
VELLORE DIST
INDIA

ELIZABETH SIVAKUMAR(SR)
FLATNO.A/7 SKYLART
APPARTMENTS,OPP HOTEL
SUMMIT PANJIM GOA,
INDIA

ELUMALAI
RAHUNATHASAMUDRAM VILLAGE &
POST 604 503,
VANDAVASI TALUK,
TIRUVANNAMALAI DIST
INDIA

Dr. ELVINO BARETTO
CHINCHIPADA CHRISTIAN HOSPITAL,
PO CHINCHIPADA,DHULIA DIST,
MAHARASTHRA
INDIA

EMILY GNANA MAGADLINE
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

Dr. EUGENE WILSON
GOVT.SIDDHA MEDICAL COLLEGE,
7-A IIST TEACHERS COLONY,
PALAVANTHANGAL,
CHENNAI 61
INDIA

99 Dr. FAROOK.A
AB-49 ANNA NAGAR,
CHENNAI
INDIA

100 Dr. FERNANADES.S.D
DEPT.OF MEDICAL EDUCATION,
INSTITUTE OF STD,
GOVT.GENERAL HOSPITAL,
CHENNAI 600 003
INDIA

101 FRANCIS PORSINGULA
WE CARE SOCIAL SERVICE SOCIETY,
RESOURCE CENTRE,
1/21 PERIA ALWAR ST N.H.I
MARAIMALAI NAGAR 603 209,
KANCHI DIST
INDIA

102 Dr. GANDHI RAJAN.P
II MD(S) STUDENT,
GOVT.SIDDH MEDICAL COLLEGE,
PALAYAMKOTTAI 627 002,
TIRUNELVELI DIST,
INDIA

103 GANDHIMATHY.P
102-A RANGARAJAPURAM
MAIN ROAD,
KODABAKKAM
CHENNAI 24
INDIA

104 Dr. GANESAN.S.P
HI TECH DIAGNOSTIC CENTRE,
NO.1 MILLERS ROAD,
CHENNAI 600 010
INDIA

105 Dr. GANGAIAH.B (SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

106 Dr. GAYATHIRI DEVI.K
L-72 MIG FLAT
RK NAGAR,MANDAVELI
CHENNAI
INDIA

107 GEETHA VENUGOPAL
PH2 COLTSVIEWAPTS,
94 PILLAIYARKOIL STREET,
MADUVANKARAI,GUINDY
CHENNAI 600 032
INDIA

108 GEORGE.G
7-B OMALUR MAIN ROAD,
FOUR ROADS,
SALEM,
TAMIL NADU
INDIA

109 GHAPURE (ARCON)
DEPT. OF INFECTIOUS DISEASES,
MGM MEDICAL COLLEGE,
KAMOTHI NAVI,
MUMBAI
INDIA

110 GLADIS DEVADOSS
4/235 COLLEGE ROAD,
THASILDAR NAGAR,
MADURAI - 20
INDIA

111 GLORIA PORSIELLO
RUSHA DEPT. CMCH,
RUSHA CAMPUS P.O.
VELLORE DISTRICT 632 209
TAMIL NADU

112 GNANASEKARAN(APAC)
SEVA NILAYAM SOCIETY,
RAJATHAM POST,
AUNDIPATTI,
MADURAI 625 512
INDIA

113 GNANASEKARAN.G(APAC)
RESEARCH AND DOCUMENTATION
SEVA NILAYAM SOCIETY,
RAJATHANI POST,AUNDIPATTI T
THEN DIST. 625 512
INDIA

114 GOMATHY.K
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM
ERODE
INDIA

115 Dr. GOPAL.P
5A,4TH CROSS,
MARAVANERI,
SALEM 636 007
INDIA

116 GOWRI SHANKAR.K.S
158 RED BLOCK,MEN'S HOSTEL,
STANLEY MEDICAL COLLEGE,
CHENNAI
INDIA

117 GREEDA ALEXANDER
CHRISTIAN MEDICAL COLLEGE &
HOSPITAL RUSHA CAMPUS
PO 632 209,
VELLORE DIST,
INDIA

118 GUNASEKARAN
SOUTHERN RAILWAY,
TRICHY DIVISION,
NO.20,V.N.DOSS STREET,
CHENNAI 600 002
INDIA

119 HARI BABU.R
29/2 VELU STREET,
WEST MAMBALAM,
CHENNAI 33
INDIA

HARI PRASAD.K
NO.19 THILAGAR STREET,
BHARATHIYAR NAGAR PATTABIRAM,
CHENNAI 72
INDIA

HARIHARAN.A.J
SECRETARY,INDIAN COMMUNITY
WELFARE ORGANISATION
1369 18TH MAIN ROAD I BLOCK
ANNA NAGAR CHENNAI 40
INDIA

HEPH ZIBAH MARIA JEEVA
4/235 COLLEGE ROAD,
THASILDAR NAGAR
MADURAI-20
INDIA

Dr. IGTY

Dr. ILANGO.J
#265 MMC MEN'S HOSTEL
PARK TOWN
CHENNAI
INDIA

ILKA WELLANDER(AUS)

Dr. INDIRA DEVI
READER,
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

INS SAIRABANU
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

Dr. IYYANAR.N
CORPORAT9ION HEALTH OFFICER,
MUNICIPAL CORPORATION OFFICE,
TIRUNELVELI - 1
INDIA

129 Dr. JADHAV.S.G
ASSOC.PROG
DEPT. OF OB & G,
JJ HOSPITAL & GRANDS
MEDICAL COLLEGE,MUMBAI
INDIA

130 Dr. JAILANI.M
SECRETARY,THIRU GANA
SAMBANDAR CHARITABLE TRUST,
5/83,KATTAMPURAM STREET,
CHINNA DHARAPURAM 639 202
INDIA

131 JAMUNA
GOVERNMENT SIDDHA COLLEGE,
PALAYAMKOTTAI
MEN'S HOSTEL,VANNARAPET
TIRUNELVELI
INDIA

132 Dr. JANARDHANA REDDY.D
DIRECTOR,
DEPT.OF ADULT EDUCATION,
S.V.UNIVERSITY,
TIRUPATI 517 502
INDIA

133 Dr. JANARTHANAN.R
POST GRADUATE STUDENT'S ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

134 JAYA KARUPPAYEE.O
EX-SERVICEMEN COLONY,
MULLAI NAGAR,
MEENAKSHIPURAM,
MADURAI 625 002
INDIA

135 Dr. JAYACHANDRAN.K
PSG INSTITUTE OF MEDICAL
SCIENCES AND RESEARCH,
COIMBATORE 641 004
INDIA

136 Dr. JAYAKUMAR.J
ST.THOMAS HOSPITAL & LEPROSY CENTRE,
CHETTUPATTU
T.V.MALAI DIST 606 801
INDIA

137 JAYANTHI.J
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

138 Dr. JAYAPAUL.K
NO.64 PV KOVIL STREET,
ROYAPURAM,
CHENNAI 600 013
INDIA

139 Dr. JAYSHREE CHOUGLEY
GM PRIYA HOSPITAL,DAPEGAON
LATUR DIST,
MAHARASTHRA
INDIA

140 JEBASEELAN SELVAKUMAR.D
KMCH COLLEGE OF PHARAMACY,
P.O.BOX 3209,
COIMBATORE
INDIA

141 JISHA M.EAPEN
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM
ERODE
INDIA

142 JOANNE SPEED(AUS)

143 JOE VASANTH
157,RED BLOCK,MEN'S HOSTEL,
STANLEY MEDICAL COLLEGE,
CHENNAI
INDIA

144 Dr. JOICE THILAGAM.J
NO.4 MMDA WATER TANK
J.T.DURAI RAJ NAGAR,
AMINGIKARAI,
CHENNAI 29
INDIA

145 JOSE.K
4/297 COLLEGE ROAD,
THASILDAR NAGAR,
MADURAI 20
INDIA

146 JOSEPH C.DANIEL
DEPT.OF MICROBIOLOGY,
ST.JOSEPH'S COLLEGE,
CUDDALORE 607 001
INDIA

147 JOSEPH DURAI SELVAM
GANDHIGRAM INSTITUTE
RURAL HEALTH,
AMBUTHURAI R.S
DINDIGUL DIST 624 302
INDIA

148 JOSEPH VINCENT.K
IMDAYAPURAM PO,
R.S.MANAGALAM VIA
RAMNAD DIST 623 525
TAMIL NADU
INDIA

149 JOSEPHINE LEO JAMILA
M/S SARA NURSING COLL
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

150 Dr. JOSHI.D.R

Dr. JOYTI.K.VARDI
C/O SHRI K.B.VARDI,
NO.10,IInd STREET,
DAE TOWNSHIP,
KALPAKKAM 603 102
INDIA

JULIE ANTHONI AMMAL.M
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

JYOTSANA KARKARE
C/O IS GILADA,
INDIAN HEALTH ORGANISATION,
MUMBAI
INDIA

Dr. KALAIVANI.S
4 CHINNA METTUPALAYAM
II STREET,THIRUVOTTIYUR
CHENNAI
INDIA

KANA INTHERARASA(AUS)

Dr. KANNAN.A.S
THE UNION PHARMA,
36 THIRD STREET EXTN SUBRAMANIAPURAM
KARAIKUDI
INDIA

Dr. KANNAN.M
POST GRADUATE STUDENT'S ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

KARMEGAM.M
NO.6,NALLAMMAL,
CHATTIRAM ROAD,
ANNAVASAL,
MADURAI
INDIA

159 KARTHIGEYAN (TEDDY)
TEDDY EXPORTS,
TENKASI ROAD,ALAMPATTI(PO)
TIRUMANGALAM 625 706
MADURAI
INDIA

160 Dr. KARUPPIAH.A
READER,
DEPT.OF SOCIOLOGY,
UNIVERSITY OF MADRAS,
CHENNAI 600 005
INDIA

161 Dr. KAUSHIK BHATTACHARYA
D/6 RAJARAM COLONY,
KODAMBAKKAM
CHENNAI 600 024
INDIA

162 KAUSTUV NAGAR
DEPT. OF ZOOLOGY,
LOYOLA COLLEGE,
64 12TH STREET II SECTOR,
KK NAGAR,CHENNAI 600 078
INDIA

163 KAVITHA
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

164 Dr. KAYAL.A
106 PG & UG HOSTEL
IOG CAMPUS,EGMORE
CHENNAI
INDIA

165 Dr. KELKAR DHANASHREE

166 KIM ZANIANG

167 KORNA DEVADANAM
H.NO.2-80,THUKALA SHAPURAM,
GUNDALA(M)-508277
DIST NALGONDA ,
A.P
INDIA

168 Dr. KOSHY GEORGE
PHYSICIAN DUNCAN HOSPITAL,
PO RAXAUL EAST CHAMPARAN,
BIHAR 845 305
INDIA

169 KOTHA JAYA PRAKASH
CHRISTIAN MEDICAL COLLEGE & HOSPITAL
VELLORE 632 004
INDIA

170 KOUSALYA.P
NO.23,BRINDAVAN STREET,
CHENNAI 28
INDIA

171 KRISHNAKUMAR.K
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

172 KRISHNAMOORTHI.D
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

173 Dr. KRISHNAMURTHY.P(SPONS)
AIDS PREVENTION AND CONTROL PROJECT,
VOLUNTARY HEALTH SERVICES,
TTTI POST,ADYAR,
CHENNAI
INDIA

174 Dr. KRISHNAVENI.M
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 106
INDIA

175 Dr. KULLANDAIVEL
THANGAM HOSPITAL,
NAMAKKAL,
TAMIL NADU
INDIA

176 KUMARESAN.G(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
CHENNAI 600 020

177 Dr. LAKSHMAN SINGH.M
PROF. & HEAD OD SOCIO
B.U
COIMBATORE
INDIA

178 Dr. LAKSHMI BAI(APAC)
SPECIALIST MER
INDIA

179 Dr. LAKSHMI.R
101A KULUVANIGAIPURAM
MAIN ROAD,
PALAYAMKOTTAI
TIRUNEVELI - 2
INDIA

180 Dr. LALITHA
CHRISTIAN MEDICAL COLL
DEPT. OF COMMUNITY MED
CHAD,BAGAYAM
VELLORE,
INDIA

181 LAVANYA.M
M-53/4,Ist MAIN RAOD,
BESANT NAGAR,
CHENNAI 90
INDIA

LEELA PRADHAN
CHAMPAK PROJECT,DUNCAN HOSPITAL,
PO RAXAUL EAST CHAMPARAN DIST,
BIHAR
INDIA

Dr. LEVION.S.K
MEDICAL SUPERINTENDENT,
JORHAT CHRISTIAN HOSPITAL,
JORHAT,
ASSAM
INDIA

Dr. LOGAMANIAN.M
G-15,IST MAIN ROAD,
BIRUNDAVAN COLONY,
ANNA NAGAR EAST,
CHENNAI
INDIA

Dr. LOGANATHAN(APAC)
CONSULTANT,
STANLEY MEDICAL COLLEGE,
CHENNAI
INDIA

LUCIA FERRAZ TABOR
CHILD & REPRODUCTIVE HEALTH PROJECT,
PROGRAM FOR ADVANCEMENT OF COMMERICAL
TECHNOLOGY PATH,SANGHA RACHNA BUILDING,
53 LODI ESTATE NEW DELHI - 3
INDIA

MAHALAKSHMI.B
SANKARA NETHARALAYA
18 COLLEGE ROAD
CHENNAI 600 006
INDIA

Dr. MAHARAJAN.M
#2 NEW PG QUARTERS
GOVERNMENT GENERAL HOSPITAL CHENNAI
CHENNAI
INDIA

MAITY
9,KALIBARI LANE,
CULCUTTA 32
INDIA

190 MALLIKA
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

191 Dr. MALLIKA
THANGAM HOSPITAL,
NAMAKKAL
TAMIL NADU
INDIA

192 MAMALLAN.A
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

193 Dr. MANICKAM.P
CHRISTIAN MEDICAL COLLEGE,
DEPT. OF COMMUNITY MEDICINE,
CHAD,BAGAYAM
VELLORE,
INDIA

194 Dr. MANIKANDHAN.S.S
INTERNATIONAL AIDS & CANCER
HOSPITALS,
MADURAVOYAL
CHENNAI-600 102
INDIA

195 MANJU MATHEW
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM
ERODE

196 Dr. MARY
DEPT. OF EXPERIMENTAL
MEDICINE,
THE TN Dr.M.G.R. MEDICAL
UNIVERSITY,GUINDY 32
INDIA

197 MARY JULIE.A
2-250,ANNA NAGAR,
CHENNAI - 40
INDIA

198 Dr. MATHEW.M

199 MAYA JOHN

200 MAYILRI JEYAKUMAR.A
5/129 MAYILRI NADAR COLONY
KRISHNAPURAM 626 143
TAMIL NADU
INDIA

201 MEENAKSHI.A (APAC)
APAC PROJECT,CHENNAI
601,MANIYAM COMPLEX,
100 FEET ROAD,
COIMBATORE 12
INDIA

202 MEERA SHANKAR(APAC)
51/16-G,
S.M.PURAM IIND STREET,
TUTICORIN
INDIA

203 MEERA.D
8,THAMPAL CHETTY STREET,
CHENNAI
INDIA

204 Dr. MENAKA.R
POST GRADUATE STUDENT'S
ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

205 MILTON VILVARAJ.D
1254 F1/1 3rd MAIN ROAD,
PHASE II,SATHUVACHARY,
VELLORE 632 009,
INDIA

206 Dr. MOHAN
PG INSTITUTE OF INTERNAL
MEDICINE
MADRAS MEDICAL COLLEGE
CHENNAI 600 001
INDIA

207 Dr. MOHAN.S
CIVIL SURGEON,
INSTITUTE OF STD,
MADRAS MEDICAL COLLEGE,
CHENNAI 600 001
INDIA

208 Dr. MOHAN.T.V
BIO CHEMISTRY DEPT.,
I.R.J PERUNDURAI MEDICAL
COLLEGE,PERUNDURAI 638 053,
ERODE DIST
INDIA

209 MUHAHEED ABDUL
S/O ABDUL WAHEED,
D.NO.18-18-50
MUFTI STREET,NEAR B R STADIUM
GUNTUR 522 001
INDIA

210 Dr. MURALI NHS(SPONS)
APAC PROJECT,VHS
TTTI POST
ADYAR,
CHENNAI
INDIA

211 MURUGESAN.N.S

212 NAGARAJ.P
37 THIRUPACHISEWAR STREET,
AYANAVARAM
CHENNAI-23
INDIA

213 Dr. NAGARAJAN.J.S
POST GRADUATE STUDENTS ASSOCIAT
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 016
INDIA

Dr. NAGESWARA RAO YARRA
GUNTUR AIDS PREVENTIVE SOCIETY
BHAGAT SINGH CENTRE KOTHAPET
GUNTUR 522 001
INDIA

NAGESWARA RAO.T
CREATIVE ACTION FRO RURAL
DEVELOPMENT,
PRAGATHI NAGAR,PEDAKAKANI
GUNTUR DIST,ANDHRA PRADESH
INDIA

NALINI GOPALKRISHNAN
SACRED HEART NURSING COLLEGE,
MADURAI-20
TAMIL NADU
INDIA

NALINI P.MOHANDOSS
8 MAHALAKSHMI STREET,
OFF.SOUTH USMAN ROAD,
OPP.MAMBALAM STATION,
T.NAGAR,CHENNAI 600 017
INDIA

Dr. NALLAIYAN.S
162,THURAINYUR ROAD,
NAMAKKAL 637 002
INDIA

NANAU
SHALOM HOSPICE,HMUIA VENG,
PO CHURACHANDPUR,
MANIPUR,
INDIA

Dr. NANDAKUMAR NAIR.U
DEPT.OF PM & R,
RM MEDICAL COLLEGE HOSPITAL,
ANNAMALAI UNIVERSITY,
TAMIL NADU
INDIA

221 NANDHINI.S
102-A RANGARAJAPURAM MAIN RAOD,
KODAMBAKKAM,
CHENNAI 24
INDIA

222 NANMOZHI
61-Ist STREET,
KAMARAJ AVENUE,
ADYAR,
CHENNAI
INDIA

223 NAPOLEAN.R
PG STUDENT IN MICROBIOLOGY,
DEPT OF MICROBIOLOGY,
TIRUNELVELI MEDICAL COLLEGE
TIRUNELVELI
INDIA

224 NARASIMHA RAO.P
DEPT.OF SOCIAL WORK,
A.M.A.L COLLEGE,
ANAKAPALLE 531 001
ANDHRA PRADESH
INDIA

225 Dr. NARIENDER K.SATIJA
DEFENCE RESEARCH & DEVELOPMENT
ORGANISATION,DEFENCE INSTITUTE
OF PHHYSIOLOGY AND ALLIED SCIENCES,
LUCKNOW ROAD TIMARPUR,DELHI-54
INDIA

226 NATARAJAN.S
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI,UG STUDENTS
TIRUNELVELI
INDIA

227 Dr. NEELAVATHY
44 SARAVANA PERUMAL STREET,
PURASAWAKKAM
CHENNAI 600 084
INDIA

228 NIRANCHAND DEVI
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

229 NIVEDHITHA.S
A3 ANSARY FLATS,
8 MADLEY ROAD,
T.NAGAR,
CHENNAI 600 017
INDIA

230 NOORI.D
133,WEST NAMASIVAYAPURAM,
CHOOLAIMEDU,
CHENNAI 94
INDIA

231 OLIVIA SCANLON(AUS)

232 OSWAL JITENDER
B.J. WADIA HOSPITAL FOR
CHILDREN,ACHARAY DONDE MARG,
PAREL,
MUMBAI- 42
INDIA

233 PADMAJA.A
NO.23 BRINDAVAN STREET,
WEST MAMBALAM
CHENNAI 33
INDIA

234 PALANI SAMUEL

235 PALANIAPPAN.P
NAMAKKAL

236 PALANISAMY.R
14 PARAMATHY ROAD,
NAMAKKAL 637 001.
INDIA

237 PANDI.K
TRACE,S.V.SNAGAR,
THIRUVALLUVAR COLONY,
JAKKAMPATTI POST,AUNDIPATTI TAL
THENI DIST. 625 512
INDIA

238 Dr. PANDIA RAJA.K
POST GRADUATE STUDENT'S ASSOCIA
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106.
INDIA

239 Dr. PARIDA.S.K
EPIDEMIOLOGIST,MINISTRY OF HEAL
MENTERI BESAR ROAD
BERAKAS BB 3910
BRUNEI

240 PAUL SAMPATH.M
80/C VEERAPPAM STREET,
POLUR 606 803
T.V.MALAI DIST
INDIA

241 Dr. PERIASAMY PANDIAN.N
LECTURER,
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 602 106.
INDIA

242 PONMALAR
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI 2
INDIA

243 Dr. PONNAN.K
POST GRADUATE STUDENTS ASSOCIAT
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 600 016
INDIA

244 Dr. POONGOTHAI.M
II M.D(S) STUDENT,
GOVT.SIDDHA MEDICAL COLLEGE,
PALAYAMKOTTAI 627 002,
TIRUNELVELI
INDIA

245 POORANI.P
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI -2
INDIA

246 POORNIMA MADHAVAN
YRG CARE NO.1,
RAMAN STREET,
T.NAGAR,
CHENNAI 600 017
INDIA

247 PORSIELLO G
RUSHA DEPARTMENT,
CHRISTIAN MEDICAL COLLEGE
AND HOSPITAL,
VELLORE 632 209
INDIA

248 Dr. PRABAKARA RAO

249 Dr. PRABHAKARA RAO.T
SWISS M.A.C.F.I
REGD.NO.12520
CIVIL ASST.SURGEON,
GOVT.GENERAL HOSPITAL,GUNTUR
INDIA

250 Dr. PRADEEP GATTANI
C/O IS GILADA,
INDIAN HEALTH ORGANISATION,
MUMBAI
JODHPUR,RAJASTHAN
INDIA

251 Dr. PRADEEP PAUL
CHRISTIAN MEDICAL COLLEGE,
DEPT. OF COMMUNITY MEDICINE,
CHAD,BAGAYAM,
VELLORE
INDIA

252 Dr. PRAKASH BORA

253 Dr. PRASAD NAIK.N
DEPT.OF STD & AIDS,
GGH OP NO.19,
GUNTUR MEDICAL COLLEGE,
GUNTUR A.P. 522 001
INDIA

254 Dr. PRASAD.P
ASST.RESEARC OFFICER,
4,BHARATHIYAR ROAD,
KANGAM
CHENNAI 13
INDIA

255 Dr. PRASAD.T.L.N
6-7-75 IST FLOOR,
7/5 ARUNDEL PET,
GUNTUR 522 002
INDIA

256 Dr. PRATIT SAMDANI
MD STUDENT
DEPT. OF MEDICINE,
JJ HOSPITAL & GRANDS
MEDICAL COLLEGE,MUMBAI
INDIA

257 Dr. PRAVIN K.KOTHARI
4D SHANAZ
90 NEPEANSEA ROAD
MUMBAI
INDIA

258 Dr. PREMKUMAR SATYA.A.J
PREMALAYA,45/1,
KANDAPPA ACHARI STREET,
PURASAWALKAM
CHENNAI
INDIA

259 PRIYA.K
SANKARAN NETHRALAYA
18 COLLEGE ROAD,
CEHNNAI 600 006
INDIA

260 PUJA AMBUWANI
C/O IS GILADA,
INDIAN HEALTH ORGANISATION,
MUMBAI
INDIA

261 PUNITHA
GOVERNMENT SIDDHA COLLEGE,
PALAYAMKOTTAI
MEN'S HOSTEL,VANNARAPET
TIRUNELVELI
INDIA

262 Dr. PUNITHA J.V
WORLD VISION OF INDIA
14 SHANMUGARYAN STREET,
PURSAIWALKAM,
CHENNAI 600 007
INDIA

263 PUNITHA.S
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

264 Dr. RAJA PRABAKARAN.M
POST GRADUATE STUDENT'S ASSOCIATION
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106.
INDIA

265 RAJA PRATAP.C

266 RAJA(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

267 RAJADURAI.S
GOVERNMENT SIDDHA COLL
PALAYAMKOTTAI MEN'S HO
VANNARAPET
TIRUNELVELI
INDIA

268 Dr. RAJAGOPAL.S
7/129 NETHAJI STREET,
SEERA NAICKEN PALAYAM
COIMBATORE 641 007
INDIA

269 Dr. RAJAGOPALAN.V
RURAL ACTION FOR LIFE
FOUNDATION,PERAIYUR,
MADURAI DIST
TAMIL NADU 625 703
INDIA

270 RAJALAKSHMI.P
GOVT.SIDDHA MEDICAL CO
PALAYAMKOTTAI
LADIES HOSTEL,
TIRUNELVELI 627 002
INDIA

271 Dr. RAJAN PATIL
CHRISTIAN MEDICAL COL
DEPT. OF COMMUNITY ME
CHAD,BHAGAYAM
VELLORE,
INDIA

RAJARAMAN.K
',SUB JAIL ROAD,
CUDDALORE
INDIA

Dr. RAJASANKAR.D
4/216 8TH STREET
SHANTHI NAGAR,PALAYAMKOTTAI
TIRUNELVELI
INDIA

RAJASEKAR.R
KMCH COLLEGE OF PHARMACY,
PO BOX 32009,
COIMBATORE
INDIA

Dr. RAJASEKARAN.S
PROF.OF THORACIC MEDICINE
GOVT.RAJA MIRASUDAR HOSPITAL,
THANJAVUR 613 001
INDIA

Dr. RAJASEKARAN.S
DOOR NO.104 V BLOCK,
PLOT NO:4269,
ANNA NAGAR
CHENNAI 600 040
INDIA

RAJASHREE
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI
INDIA

RAJESH KUMAR
GOVERNMENT SIDDHA MEDICAL
COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

Dr. RAJESH RAGOPALAN
#5,NEW P.G. QUARTERS
MADRAS MEDICAL COLLEGE
CHENNAI
INDIA

280 Dr. RAJINIKANTH.S
POST GRADUATE STUDENT'S ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

281 Dr. RAJKUMAR.S
POST GRADUATE STUDENT'S ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106.
INDIA

282 Dr. RAM MOHAN RAO.C.H
DEPT. OF STD,
OP.NO.19 GGH GUNTUR,
GUNTUR MEDICAL COLLEGE,
ANDHRA PRADESH 522 001
INDIA

283 Dr. RAMA CHANDRA SAHOO
RAMARAJYA,
KORAPUR 764 020
ORISSA
INDIA

284 Dr. RAMAMURTHI.K
INTERNATIONAL AIDS & CANCER
HOSPITALS,
MADURAVOYAL
CHENNAI-602 102
INDIA

285 Dr. RAMANA RAO.R.V
GUNTUR MEDICAL COLLEGE,
GUNTUR,
ANDHRA PRADESH 522 001
INDIA

286 RAMANAN.V
NO.1 RAMAN STREET,
T.NAGAR,
CHENNAI 17
INDIA

287 Dr. RAMESH (SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

288 Dr. RAMESH.E
BLOOD BANK,
VIJAYA HOSPITAL,
NSK SALAI,
CHENNAI
INDIA

289 RAMESH.V
JUNIOR LECTURER,
COLLEGE OF NURISING
CHRISTIAN MEDICAL COLLEGE &
HOSPITAL,VELLORE
INDIA

290 RAMKUMAR.S
N0.5 6th CROSS STREET,
BRINDAVAN,
PONDICHERRY 13
INDIA

291 RAMKUMAR.T.S
DIRECTOR,CENTRE FOR
SOCIAL RECONSTRUCTION,
26 A/1 BEACH ROAD,NEAR S.T.
HINDU COLLEGE,NAGERCOIL 629 002
INDIA

292 RANE (ARCON)
DEPT. OF INFECTIOUS DISEASES,
MGM'S MEDICAL COLLEGE,
KAMOTHI,NAVI,
MUMBAI
INDIA

293 RANGANATHAN KANNAN
RAGAS DENTAL COLLEGE & HOSPITAL,
116,R.K.SALAI,
MYLAPORE,
CHENNAI 4
INDIA

294 Dr. RANGANATHAN.K
RAGAS DENTAL COLLEGE & HOSPI
MYLAPORE,
CHENNA 600 004
INDIA

295 RANGANAYAKI.L
GOVT SIDDHA MEDICAL COLLEGE
PALAYAMKOTTAI
TIRUNELVELI -2
INDIA

296 Dr. RATH.P.K
CONSULTANT PATHOLOGIST,
SEAHORSE HOSPITAL LTD,
TRICHY 620 001
INDIA

297 RAVI CHANDRAN.M
C/o Dr.S.BHUVANESWARI,
14th WARD, STD DEPT,
GOVERNMENT GENERAL HOSPITAL,
CHENNAI 600 003
INDIA

298 RAVI NATHAN.R
170 BARATHIAR ST,
MANALI 600 068
INDIA

299 RAVI RAJ WILLIAM (APAC)
CHRISTIAN COUNCIL FOR
RURAL DEVELOPMENT & RESEARCH
WILLEE HOSPITAL COMPLEX,
THIRUVALLUR DIST
INDIA

300 Dr. RAVI SUBRAMANIAN
#5,NEW P.G. QUARTERS
MADRAS MEDICAL COLLEGE
CHENNAI
INDIA

Dr. RAVI VADREVU
21-1-14 JAWAHAR STREET,
SALIPETA,
KAKINADA 533 001
INDIA

Dr. RAVICHANDRAN.M
POST GRADUATE STUDENT'S ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

Dr. RAVINDRA.R
G-9 TSPL DISPENSARY,
PO T.B.DAM BELLARY VIA
INDIA

RELTON.A
LECTURE(SG),
DEPT.OF SOCIAL WORK,
BISHOP HEBER COLLEGE,
TIRUCHIRAPALLI 620 017
INDIA

Dr. RENGANATHAN.S
POST GRADUATE STUDENT'S ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106.
INDIA

Dr. RENGARAJ NAIDU.K
RURAL ACTION FOR LIFE
FOUNDATION,
PERAIYUR,
MADURAI DIST 625 703
INDIA

Dr. REV KARUNAKAR.J.P.
SANTHOSHAMMA HOSPITAL,
NARAYANAPET,
MAHAHUH NAGAR DIST
ANDHRA PRADESH,
INDIA

308 REV.PAUL NILAVAN CHRISTUDOSS
ADDRE CENTRE,
NO.16 ATHIPET,MAIN ROAD,
OLD AMBATTUR(KUPPAM)
CHENNAI 58
INDIA

309 REV.SAMPATH.J
7,SRINIVASA STREET,
TINDIVANAM,
TAMIL NADU
INDIA

310 RITA JAMES(APAC)
TEDDY EXPORTS,
TENKAŚI ROAD,ALAMPATTI(PO)
TIRUMANGALAM 625 706
MADURAI
INDIA

311 ROGOTHAMAN.Y.M.
3 FIRST CROSS STREET
KODAMBAKKAM
CHENNAI
INDIA

312 Dr. ROHIBIN ISWARI

313 ROSHAN KUMAR(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

314 ROSHAN KUMAR.D(SR)
DIRECTOR,
PO BOX NO:249
3rd LANE SRINAGAR,
GUNTUR 522 002,A.P
INDIA

315 Dr. ROSHINI BHAGWAT
19 HABIB COURT SHAHID
BHAGAT SINGH ROAD,
COLABA,
MUMBAI 400 039
INDIA

316 Dr. RUATA
MIZORAM SHALOM PROJECT,
CHALTLANG,VANHELA BLDNG,
PO AIZAWL
MIZORAM
INDIA

317 Dr. SACHIN CHANGEDIA
MUMBAI
INDIA

318 Dr. SACHIN MANOCHA
DR.ALM RG INSTITUTE OF
BASIC MEDICAL SCIENCE
UNIVERSITY OF MADRAS
TARAMANI,CHENNAI 600 113
INDIA

319 SADHASIVAM.M
ROOM NO.25 GARDIAN MANSON
21 D.V.STREET,
TRIPLICANE,
VHS CHENNAI 113
INDIA

320 Dr. SAJITH KUMAR.R
CHANDRATHIL,
KUDAMALOOR P.O.,
KOTTAYAM 686 017
KERALA
INDIA

321 SAKSENA.M.B
C/O IS GILADA,
INDIAN HEALTH ORGANISATION,
MUMBAI
INDIA

322 Dr. SAMPATH.V(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

323 SAMSON RAHI
ACT PROJECT,
DUNCAN HOSPITAL,
PO RAXAUL EAST

324 Dr. SANDEEP RAMALINGAM
DEPT.OF CLINICAL VIROLOGY
CHRISTIAN MEDICAL COLLEGE AND HOSP
VELLORE 632 004
INDIA

325 Dr. SANJIDA KHWAJA
B5 - ANNA UNIVERSITY QTRS
ADJ TO BIRLA PLANETORIUM
CHENNAI
INDIA

326 SANKAR
51/16-G,
S.M.PURAM II STREET,
TUTICORIN - 3
INDIA

327 Dr. SARAH CHERIAN
MEDICAL OFFICER,BROADWELL CHRISTIAN
HOSPTIAL,
PO FATEHPUR,
UP,
INDIA

328 Dr. SARAVANA KOODAM.S
POST GRADUATE STUDENT'S ASSOCIATION
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106.
INDIA

329 Dr. SARTHAJ BEGUM.A.R.
POST GRADUATE STUDENTS ASSOCIATION
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

330 Dr. SASI.S.K
44 SARAVANA PERUMAL STREET,
PURASAWAKKAM
CHENNAI 600 084
INDIA

331 SATHEESH KUMAR.S
DEPT.OF MICROBIOLOGY,
DR.A/M PG INSTITUTE OF BASIC MEDICA
SCIENCE,TARAMANI
CHENNAI
INDIA

2 SATHEESH RAYEN.J
GURUKUL CLINIC
94 PURASWAIKKAM HIGH ROAD,
KELLYS
CHENNAI 600 010
INDIA

3 Dr. SATHYA NARAYANAN.K
POST GRADUATE STUDENT'S
ASSOICATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106.
INDIA

4 SATHYA.T
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE DIST
INDIA

5 SATHYANARAYANAN.B
SOGODHAR
32 S.G.K. IST STREET
CHENNAI
INDIA

6 SEETHALAKSHMI.K
102-A RANGARAJAPURAM
MAIN ROAD,
KODABAKKAM
CHENNAI
INDIA

7 SEKAR.B
5,NATRAJAN STREET,
JAFERKANPET,
CHENNAI 83
INDIA

8 SELVA KUMAR.A
RUSHA DEPT,CHRISTIAN MEDICAL
COLLEGE & HOSPITAL,
RUSHA CAMPUS PO 632 209,
VELLORE DIST,
INDIA

339 SELVAM.D
8/58,
SAKTHI VINAYAGAR ST,
VILANDAI
ANDIMADAM
INDIA

340 SELVI

341 SEN.M (ARCON)
DEPT.OF APPLIED PSYCHOLOGY,
UNIVERSITY OF MUMBAI,
VIDYANAGARI,SANTACRUZ(E),
MUMBAI 400 098
INDIA

342 Dr. SENTHIL KUMAR.K
POST GRADUATE STUDENT'S ASSOCIATION,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

343 SENTHIL KUMAR.K.L
PADMAVATHI COLLEGE OF PHARMACY,
KRISHNAGIRI MAIN RAOD,
PERIYANNAHALLI(PO)
DHARMAPURI 635 205
INDIA

344 SENTHIL KUMAR.S
THAYAGAM 35 BRINDAVAN NAGAR EXTN
ADAMBAKKAM
CHENNAI
INDIA

345 Dr. SENTHIL KUMAR.S
POST GRADUATE STUDENTS ASSOCIATION,
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 600 016
INDIA

346 SETHURAMAN.M.C
50,METTU STREET
ANNAVASAL 622 101
PUDUKKOTTAI DIST,
TAMIL NADU
INDIA

347 SHANMUGA SUNDARAM.P
9A SUBRAYAN NAICKER STREET,
AVVAI NAGAR
CHOOLAIMEDU
CHENNAI
INDIA

348 SHANMUGAPRIYA
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

349 SHANTHI (APAC)
TEDDY EXPORTS,
TENKASI ROAD,ALAMPATTI(PO)
TIRUMANGALAM 625 706
MADURAI
INDIA

350 Dr. SHANTHI DAVIDAR
B-24 TOWER BLOCK
TAYLORS ROAD,
KILPAUK,
CHENNAI 600 010
INDIA

351 SHANTHI.M
SARA NURSING COLLEGE,
NO.6 MEENACHIPURAM,
KARUR MAIN ROAD,
DHARAPURAM,ERODE DIST,
TAMIL NADU
INDIA

352 Dr. SHAW.R
DIRECTOR, COUNCIL FOR RESERARCH
HOMEOPATHY,61-65 INST AREA
O BLOCK,JANAKPURI
NEW DELHI 110 057
INDIA

353 SHERIN SHAJU NELLISSERY
MAR KUNDUKULAM MEMORIAL,
RESEARCH AND REHABILITATI
COMPLEX PERINGANDOOR,
TRICHUR 680 581,KERALA
INDIA

354 SHIBY DANIEL
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

355 SHIVKUMAR.N
CATALYST MANAGEMENT
SERVICES,
BANGALORE,
KARNATAKA 560 094
INDIA

356 SHYAMALA ASHOK
SOCIETY FOR DEVELOPMENT R
& TRAINING (SFDRI) PONDIC
34 CHETTY STREET,
PONDICHERRY -1
INDIA

357 Dr. SIJU SENA
CHRISTIAN MEDICAL COLLEGE
DEPT. OF COMMUNITY MEDICI
CHAD,BHAGAYAM
VELLORE,
INDIA

358 SIMON.A
18/A-E.B COLONY,
MAHARAJAPURAM,
VILLUPURAM 605 602
TAMIL NADU
INDIA

359 Dr. SING.V.P
CLINICAL RESEARCH UNIT FO
HOMOEOPATHY,
4,BHARATHIYAR STREET,
KANGAM,CHENNAI-13
INDIA

0 SIVA KUMAR M.N
POPULATION RESEARCH CENTRE,
ISEC, NAGARTHAVI,
P.O. BANGALORE 560 072
INDIA

1 SIVA RAM.T
DEPT.OF BIOCHEMISTRY,
UNIVERSITY OF HYDERABAD,
HYDERABAD 500 046,
INDIA

2 SIVAKUMAR.A
DEPT.OF PEDIATRICS,
KILPAUK MEDICAL COLLEGE,
CHENNAI-600 10
INDIA

3 SIVAKUMAR.M.N

4 SMITHA SAMUEL
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM
ERODE
INDIA

55 Dr. SOUNDARARAJAN.D.K
3D D2 ROAD,
BALARENGAPURAM
MADURAI
INDIA

56 SOUNDRA PANDIAN.K (APAC)
CO-ORDINATOR,
CETC,
MMHRC
INDIA

367 SRIDHARAN.R
CHILD & REPRODUCTIVE HEALTH PROJECT,
PROGRAM FOR ADVANCEMENT OF COMMERICAL
TECHNOLOGY PATH,SANGHA RACHNA BUILDING,
53 LODHI ESTATE,NEW DELHI -3
INDIA

368 SRINIVASAN.N
NO-5 NATARAJAN ST,
CHENNAI - 83
INDIA

369 SRIRAM.J
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

370 Dr. SRIVANI.S
21 RAJESH APARTMENTS,
GIRIPURAM A.P
TIRUPATHI 517 507
INDIA

371 STANLEY(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

372 Dr. SUBASHREE.G
#14 VINAYAGAR STREET,
VELLACHER,
CHENNAI
INDIA

373 Dr. SUBBARATHNAM.S
33 STATE BANK COLONY,
TRICHY 620 012
TAMIL NADU
INDIA

374 Dr. SUBRAMANIAM.R

375 SUBRAMANIAN.S
13/4 BRINDAVAN APARTMENTS
IVTH CROSS ,ANDAL NAGAR
ADAMBAKKAM,CHENNAI
INDIA

376 SUCILA PANDIAN.P
CAST,
POTTHATANKUDIERUPPU 627 414,
CHERNMAHADEVI(VIA)
TIRUNELVELI DIST
INDIA

377 Dr. SUGUMARAN.P
POST GRADUATE STUDENTS
ASSOCIATION
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

378 Dr. SUGUNA CHANDRASEKARAN
NO.33 ZION NAGAR,
RANIPET 632 401
INDIA

379 SULEKHA.S.B
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

380 SUNDAR.M
DEPT.OF COMMUNITY MEDICINE,
KIMS,VV PURAM,
KR ROAD,
BANGALORE 560 004
INDIA

381 Dr. SURENDRAN.V
PLOT 242,39TH ST,
8TH SECTOR,
WEST K.K.NAGAR,
CHENNAI
INDIA

382 Dr. SURESH KUMAR.A
POST GRADUATE STUDENT'S ASSOCI
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

383 SURESH KUMAR.R
DEPT.OF BIOCHEMISTRY,
CANCER INSTITUTE,
ADYAR,
CHENNAI - 20
INDIA

384 Dr. SURYA PRAKASH(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

385 SUSAN HEMA.A.H
NO.5 NATARAJAN STREET
BALAKRISHNAN NAGAR JAFFERKHANPE
CHENNAI 83
INDIA

386 SUSAN PETERSON(AUS)

387 SUSHMA JADHAV
NARI,
PUNE
INDIA

388 SWARLI KURLE
NARI
PUNE
INDIA

0 SIVA KUMAR M.N
POPULATION RESEARCH CENTRE,
ISEC, NAGARTHAVI,
P.O. BANGALORE 560 072
INDIA

1 SIVA RAM.T
DEPT.OF BIOCHEMISTRY,
UNIVERSITY OF HYDERABAD,
HYDERABAD 500 046,
INDIA

2 SIVAKUMAR.A
DEPT.OF PEDIATRICS,
KILPAUK MEDICAL COLLEGE,
CHENNAI-600 10
INDIA

3 SIVAKUMAR.M.N

4 SMITHA SAMUEL
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM
ERODE
INDIA

5 Dr. SOUNDARARAJAN.D.K
3D D2 ROAD,
BALARENGAPURAM
MADURAI
INDIA

6 SOUNDRA PANDIAN.K (APAC)
CO-ORDINATOR,
CETC,
MMHRC
INDIA

367 SRIDHARAN.R
CHILD & REPRODUCTIVE HEALTH PROJECT,
PROGRAM FOR ADVANCEMENT OF COMMERICAL
TECHNOLOGY PATH,SANGHA RACHNA BUILDING,
53 LODHI ESTATE,NEW DELHI -3
INDIA

368 SRINIVASAN.N
NO-5 NATARAJAN ST,
CHENNAI - 83
INDIA

369 SRIRAM.J
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

370 Dr. SRIVANI.S
21 RAJESH APARTMENTS,
GIRIPURAM A.P
TIRUPATHI 517 507
INDIA

371 STANLEY(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

372 Dr. SUBASHREE.G
#14 VINAYAGAR STREET,
VELLACHER,
CHENNAI
INDIA

373 Dr. SUBBARATHNAM.S
33 STATE BANK COLONY,
TRICHY 620 012
TAMIL NADU
INDIA

374 Dr. SUBRAMANIAM.R

375 SUBRAMANIAN.S
13/4 BRINDAVAN APARTMENTS
IVTH CROSS ,ANDAL NAGAR
ADAMBAKKAM,CHENNAI
INDIA

376 SUCILA PANDIAN.P
CAST,
POTTHATANKUDIERUPPU 627 414,
CHERNMAHADEVI(VIA)
TIRUNELVELI DIST
INDIA

377 Dr. SUGUMARAN.P
POST GRADUATE STUDENTS
ASSOCIATION
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

378 Dr. SUGUNA CHANDRASEKARAN
NO.33 ZION NAGAR,
RANIPET 632 401
INDIA

379 SULEKHA.S.B
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

380 SUNDAR.M
DEPT.OF COMMUNITY MEDICINE,
KIMS,VV PURAM,
KR ROAD,
BANGALORE 560 004
INDIA

381 Dr. SURENDRAN.V
PLOT 242,39TH ST,
8TH SECTOR,
WEST K.K.NAGAR,
CHENNAI
INDIA

382 Dr. SURESH KUMAR.A
POST GRADUATE STUDENT'S ASSOCI
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

383 SURESH KUMAR.R
DEPT.OF BIOCHEMISTRY,
CANCER INSTITUTE,
ADYAR,
CHENNAI - 20
INDIA

384 Dr. SURYA PRAKASH(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

385 SUSAN HEMA.A.H
NO.5 NATARAJAN STREET
BALAKRISHNAN NAGAR JAFFERKHANPI
CHENNAI 83
INDIA

386 SUSAN PETERSON(AUS)

387 SUSHMA JADHAV
NARI,
PUNE
INDIA

388 SWARLI KURLE
NARI
PUNE
INDIA

0 SIVA KUMAR M.N
POPULATION RESEARCH CENTRE,
ISEC, NAGARTHAVI,
P.O. BANGALORE 560 072
INDIA

1 SIVA RAM.T
DEPT.OF BIOCHEMISTRY,
UNIVERSITY OF HYDERABAD,
HYDERABAD 500 046,
INDIA

2 SIVAKUMAR.A
DEPT.OF PEDIATRICS,
KILPAUK MEDICAL COLLEGE,
CHENNAI-600 10
INDIA

3 SIVAKUMAR.M.N

4 SMITHA SAMUEL
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM
ERODE
INDIA

5 Dr. SOUNDARARAJAN.D.K
3D D2 ROAD,
BALARENGAPURAM
MADURAI
INDIA

6 SOUNDRA PANDIAN.K (APAC)
CO-ORDINATOR,
CETC,
MMHRC
INDIA

367 SRIDHARAN.R
CHILD & REPRODUCTIVE HEALTH PROJECT,
PROGRAM FOR ADVANCEMENT OF COMMERICAL
TECHNOLOGY PATH,SANGHA RACHNA BUILDING,
53 LODHI ESTATE,NEW DELHI -3
INDIA

368 SRINIVASAN.N
NO-5 NATARAJAN ST,
CHENNAI - 83
INDIA

369 SRIRAM.J
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

370 Dr. SRIVANI.S
21 RAJESH APARTMENTS,
GIRIPURAM A.P
TIRUPATHI 517 507
INDIA

371 STANLEY(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

372 Dr. SUBASHREE.G
#14 VINAYAGAR STREET,
VELLACHER,
CHENNAI
INDIA

373 Dr. SUBBARATHNAM.S
33 STATE BANK COLONY,
TRICHY 620 012
TAMIL NADU
INDIA

374 Dr. SUBRAMANIAM.R

375 SUBRAMANIAN.S
13/4 BRINDAVAN APARTMENTS
IVTH CROSS ,ANDAL NAGAR
ADAMBAKKAM,CHENNAI
INDIA

376 SUCILA PANDIAN.P
CAST,
POTTHATANKUDIERUPPU 627 414,
CHERNMAHADEVI(VIA)
TIRUNELVELI DIST
INDIA

377 Dr. SUGUMARAN.P
POST GRADUATE STUDENTS
ASSOCIATION
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

378 Dr. SUGUNA CHANDRASEKARAN
NO.33 ZION NAGAR,
RANIPET 632 401
INDIA

379 SULEKHA.S.B
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

380 SUNDAR.M
DEPT.OF COMMUNITY MEDICINE,
KIMS,VV PURAM,
KR ROAD,
BANGALORE 560 004
INDIA

381 Dr. SURENDRAN.V
PLOT 242,39TH ST,
8TH SECTOR,
WEST K.K.NAGAR,
CHENNAI
INDIA

382 Dr. SURESH KUMAR.A
POST GRADUATE STUDENT'S ASSOCI
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

383 SURESH KUMAR.R
DEPT.OF BIOCHEMISTRY,
CANCER INSTITUTE,
ADYAR,
CHENNAI - 20
INDIA

384 Dr. SURYA PRAKASH(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

385 SUSAN HEMA.A.H
NO.5 NATARAJAN STREET
BALAKRISHNAN NAGAR JAFFERKHANPE
CHENNAI 83
INDIA

386 SUSAN PETERSON(AUS)

387 SUSHMA JADHAV
NARI,
PUNE
INDIA

388 SWARLI KURLE
NARI
PUNE
INDIA

0 SIVA KUMAR M.N
POPULATION RESEARCH CENTRE,
ISEC, NAGARTHAVI,
P.O. BANGALORE 560 072
INDIA

1 SIVA RAM.T
DEPT.OF BIOCHEMISTRY,
UNIVERSITY OF HYDERABAD,
HYDERABAD 500 046,
INDIA

2 SIVAKUMAR.A
DEPT.OF PEDIATRICS,
KILPAUK MEDICAL COLLEGE,
CHENNAI-600 10
INDIA

3 SIVAKUMAR.M.N

4 SMITHA SAMUEL
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM
ERODE
INDIA

5 Dr. SOUNDARARAJAN.D.K
3D D2 ROAD,
BALARENGAPURAM
MADURAI
INDIA

6 SOUNDRA PANDIAN.K (APAC)
CO-ORDINATOR,
CETC,
MMHRC
INDIA

367 SRIDHARAN.R
CHILD & REPRODUCTIVE HEALTH PROJECT,
PROGRAM FOR ADVANCEMENT OF COMMERICAL
TECHNOLOGY PATH,SANGHA RACHNA BUILDING,
53 LODHI ESTATE,NEW DELHI -3
INDIA

368 SRINIVASAN.N
NO-5 NATARAJAN ST,
CHENNAI - 83
INDIA

369 SRIRAM.J
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

370 Dr. SRIVANI.S
21 RAJESH APARTMENTS,
GIRIPURAM A.P
TIRUPATHI 517 507
INDIA

371 STANLEY(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

372 Dr. SUBASHREE.G
#14 VINAYAGAR STREET,
VELLACHER,
CHENNAI
INDIA

373 Dr. SUBBARATHNAM.S
33 STATE BANK COLONY,
TRICHY 620 012
TAMIL NADU
INDIA

374 Dr. SUBRAMANIAM.R

375 SUBRAMANIAN.S
13/4 BRINDAVAN APARTMENTS
IVTH CROSS ,ANDAL NAGAR
ADAMBAKKAM,CHENNAI
INDIA

376 SUCILA PANDIAN.P
CAST,
POTTHATANKUDIERUPPU 627 414,
CHERNMAHADEVI(VIA)
TIRUNELVELI DIST
INDIA

377 Dr. SUGUMARAN.P
POST GRADUATE STUDENTS
ASSOCIATION
GOVT. SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

378 Dr. SUGUNA CHANDRASEKARAN
NO.33 ZION NAGAR,
RANIPET 632 401
INDIA

379 SULEKHA.S.B
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

380 SUNDAR.M
DEPT.OF COMMUNITY MEDICINE,
KIMS,VV PURAM,
KR ROAD,
BANGALORE 560 004
INDIA

381 Dr. SURENDRAN.V
PLOT 242,39TH ST,
8TH SECTOR,
WEST K.K.NAGAR,
CHENNAI
INDIA

382 Dr. SURESH KUMAR.A
POST GRADUATE STUDENT'S ASSOCI
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

383 SURESH KUMAR.R
DEPT.OF BIOCHEMISTRY,
CANCER INSTITUTE,
ADYAR,
CHENNAI - 20
INDIA

384 Dr. SURYA PRAKASH(SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

385 SUSAN HEMA.A.H
NO.5 NATARAJAN STREET
BALAKRISHNAN NAGAR JAFFERKHANP
CHENNAI 83
INDIA

386 SUSAN PETERSON(AUS)

387 SUSHMA JADHAV
NARI,
PUNE
INDIA

388 SWARLI KURLE
NARI
PUNE
INDIA

389 TAMILSELVI.B
47,MAVEAMAN KOVIL STREET,
M-72 THANDRVI,
PATTUPERAM
INDIA

390 Dr. THANGAVEL
CHRISTIAN MEDICAL COLLEGE,
DEPT. OF COMMUNITY MEDICINE,
CHAD,BAGAYAM,
VELLORE
INDIA

391 Dr. THANKANATHAN.M.K
DISTRICT AIDS CELL,
DISTRICT HOSPITAL,
KOTTAYAM
INDIA

392 Dr. THIAGARAJAN.G
LECTURE,
GOVT.SIDDHA MEDICAL COLLEGE,
CHENNAI 600 106
INDIA

393 THIRUVARASAN.G

394 THIRUVENGADAM(TEDDY)
TEDDY EXPORTS,
TENKASI ROAD,ALAMPATTI(PO)
TIRUMANGALAM 625 706
MADURAI
INDIA

395 Dr. THOMAS V.CHACKO
PROF & HEAD COMMUNITY MEDICINE,
PSGIMSR,
COIMBATORE 641 004
INDIA

396 Dr. THOWFEEQ AHMED.K.T
MADRAS MEDICAL COLLEGE,
CHENNAI 600 003
INDIA

397 TIMOTHY.E
31 RAJESH NAGAR NARAYANAPURAM,
PALLIKARANAI 601 302
MMC
CHENNAI 601 302
INDIA

398 TRICYMOL LUKOSE
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

399 Dr. UDAYAKUMAR.J
5/16 PILLAIYAR KOVIL LANE,
SAKKOTTAI(PO),
KUMBAKONAM TK,
THANJAVUR DIST
INDIA

400 Dr. UMAIYAL.M
RSRM STANLEY MADRAS
NO.51 LAKSHMIPURAM EXTN.,
CHENNAI - 45
INDIA

401 Dr. UMAKANTHAN.S.M
HOUSE NO:2,PLOT NO:16,
USHA NAGAR,IInd STREET,
ULLAGARAM,MADIPAKKAM P.O
CHENNAI 600 009
INDIA

402 Dr. UMAMAHESWARI.S
DEPT.OF MICROBIOLOGY,
DR.A/M PG INSTITUTE OF
BASIC MEDICAL
SCIENCE,TARAMANI
CHENNAI
INDIA

403 Dr. UMAPATHY.P
NO.40 3rd STREET,
V.R.PURAM SALIGRAMAM
CHENNAI-93
INDIA

404 Dr. VAIRAMANI.R
6/426-A E.B. COLONY,
PARAMATHY ROAD,
NAMAKKAL
TAMIL NADU
INDIA

405 VARAPRASAD (SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

406 VARDHAN (SR)
COMMUNITY ACTION TRUST
9 Ist FLOOR 4th STREET,
PADMANABHA NAGAR,ADYAR
CHENNAI 600 020
INDIA

407 Dr. VASANTHA ELANGO
DEPT.OF COM MED,
PSG IMS & R
PEELAMEDU
COIMBATORE
INDIA

408 Dr. VELU.C.V
ASSUMPTION HOSPITAL,
SULTHAN BATTERY,
KERALA 673 592
INDIA

409 Dr. VENKAKTESAN.C
#9 NEW PG QUARTERS
GOVERNMENT GENERAL HOSPITAL
CHENNAI
INDIA

410 Dr. VENKATARAMAN.C
RESEARCH OFFICER,
CLINICAL RESEARCH UNIT,
6-7-61(A) K.T.ROAD,
TIRUPATHI 517 501
INDIA

411 Dr. VENKATESWARA RAO
ASSOC. PROF OF MICROBIOLOGY,
MAMATA MEDICAL COLLEGE,
KHAMMAM 507 002
ANDHRA PRADESH
INDIA

412 Dr. VENKATESWARAN.K
74 COLLECTORATE COLONY AMINIJIKA
CHENNAI 600 029
INDIA

413 Dr. VENTHAMARAI SELVI J.P
55 PANCHALI AMMAN KOIL
STREET,
ARUMBAKKAM
CHENNAI 600 106
INDIA

414 VENU GOPAL.A
14A/1,FOURTH STREET,
R.R COLONY
CHENNAI 83
INDIA

415 VERTICHELVAN.M
LAB.SUPERVISOR,
AIDS SURVEILLANCE CENTRE,
VIROLOGY RESEARCH LAB.,
INSTITUTE OF MICROBIOLOGY,
MADURAI MEDICAL COLLLEGE,MADURAI
INDIA

416 VIDHYA P.REDDY
M/S SARA NURSING COLLEGE,
6 KARUR MAIN ROAD,
DHARAPURAM 638 673
ERODE
INDIA

417 Dr. VIJAY PRABHU
64 CHESNEY NILGIRI
59 COMMANDER IN CHIEF ROAD,
CHENNAI
INDIA

418 VIJAY.A.G.
GOVERNMENT SIDDHA MEDICAL COLLEGE
PALAYAMKOT
TIRUNELVELI
INDIA

419 Dr. VIJAYA SRINIVASAN
AMBATHURAI R.S,
DINDIGUL DISTRICT,
TAMIL NADU 624 302
INDIA

420 Dr. VIJAYAKUMAR.V
PLOT NO.20 SELVAPURAM
NEAR AIC NAGAR
SALEM
INDIA

421 Dr. VIJAYALAKSHMI.J
M/S MED TECH PRODUCTS LTD,
S-59 20TH STREET,
ANNA NAGAR WEST
CHENNAI
INDIA

422 VIJAYANAD.P
CRRI,PERUNDURAI MEDICAL COLLEGE
& HOSPITAL,
PERUNDURAI
INDIA

423 VIJAYARAMAN.A (APAC)
SIVANILAYAM SOCIETY,
RAJATHANI POST,
AUNDIPATTI 625 512
MADURAI
INDIA

424 Dr. VILVANATHAN ANU RADHA
301-B PILKINGTON ROAD,
PERAMBUR RAILWAY QUARTERS,
AYANAVARAM
CHENNAI
INDIA

425 VIMAL KISHORE.K
MAMALA MEDICAL COLLEGE,
ROTARY NAGAR KHAMMAM,
ANDHRA PRADESH 507 002
INDIA

426 Dr. VIPIN PORWAL
MD STUDENT
DEPT. OF MEDICINE,
JJ HOSPITAL & GRANDS
MEDICAL COLLEGE,MUMBAI
INDIA

427 VISWANATH
DEPT. OF EXPERIMENTAL
MEDICINE,
THE TN Dr.M.G.R. MEDICAL
UNIVERSITY,GUINDY 32
INDIA

428 ZAFARULLAH (APAC)
VHS,APAC,
T.T.T.E POST,
ADYAR,
CHENNAI - 113
INDIA

429 ZEENATH UNNISA.A
144/1 ALWARPET STREET,
ALWARPET,
CHENNAI 600 018
INDIA

430 ZOE SOBHANA.P
4/235 COLLEGE ROAD,
THASILDAR NAGAR,
MADURAI-20
INDIA

Acknowledgements

The Conference Organising Committee would like to extend its thanks t
the individuals, agencies and companies for their support in particula

Tamilnadu State AIDS Control Society

National AIDS Control Organisation

Office of AIDS Research, National Institute of Health (NIH), USA

APAC -AIDS Prevention and Control Project

International AIDS Society

Elizabeth Glaser Paediatric AIDS Foundation, USA

Global Strategies for HIV Prevention, USA

Glaxo Wellcome

Boehringer Ingelheim

Mrs.Amanda Murphy, Teddy Exports

Dr.V.Gopal, Principal, CL Baid Metha College of Pharmacy
and the team of volunteers

Mr . Ramani and Mr . Ramesh

Ms.Dershana Nair

Dr.Helga Rubsamen Waigmann, Germany

Mrs.Usha Parameswaran and her team

Mrs. Madhu

Teddy Travels

Officers and Staff of the Tamilnadu Dr.M.G.R Medical University

Mrs.Kamala Ravikumar of Creative Colours Art Institute
and her team of children

Staff of Hotel Savera

Edited and published by
Dr. N. M. Samuel
Professor and Head
Department of Experimental Medicine & AIDS Resource Center
40, Anna Salai
Chennai 600 032
India